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ORIGINAL LECTURES.

ON BRONCHITIS IN CHILDREN.

A Clinical Lecture.

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GENTLEMEN: The subject that claims your attention this morning is bronchitis. Though not essentially different from the same disease in the adult, its extreme frequency in early life entitles it to special consideration.

By bronchitis, we understand an inflammation of the lining of some and possibly all of the bronchial tubes. It is a malady characterized by great differences as to severity and danger. It may be so mild as scarcely to merit notice, or so severe as to defy treatment and lead to speedy death.

Its most frequent cause is exposure to cold with dampness. It is, therefore, like other acute affections of the respiratory organs, much more likely to occur in the fall, and winter, and early spring than in midsummer.

You will not wonder that it sometimes occurs epidemically, when you reflect that a state of the atmosphere that would favor its advent in one person, might, with equal reason, render multitudes of others liable to it. Influenza is the name given to epidemic bronchitis. In our climate, it is, I think, most common in March and April. In some seasons it is exceedingly severe, affecting indiscriminately all classes and ages.

Often, too, bronchitis is secondary to other diseases. In fact it is a pretty constant attendant on measles and whooping-cough, and pneumonia, and pulmonary phthisis. In croup, diphtheria, scarlet fever, and the continued fevers it frequently appears as a troublesome and dangerous complication. Dentition also seems to favor attacks of bronchial catarrh, and you will have frequent occasion to notice the concurrence of the two conditions.

The symptoms vary, as you would suppose, with the extent and intensity of the inflammation. In its simplest form we know it as a "cold on the chest," and it is apt to be preceded and attended by the usual phenomena of a coryza. There is sneezing and nasal discharge; the eyes are suffused; the head feels stuffed; very likely the throat becomes sore, and soon the child begins to cough. If old enough, it may complain of tightness and soreness over the chest. In young infants there is often an outcry with every cough. As the thorax becomes affected, relief is apt to come to the head and throat, as if the cold had moved downward.

The cough, at first, is harsh and dry, because the usual moisture of the bronchial tubes is diminished or suppressed. If, at this early stage you lay your ear to the chest, you will hear, besides the respiratory murmur some sonorous and sibilant râles. After two or three days the secreting function of the bronchial mucous membrane is restored and the cough becomes loose and rattling. Indeed, it is more than restored, for the secretion is changed in quality and largely increased in amount. Thin and colorless at first, it soon becomes semi-transparent and thicker, and a little later is yellowish and opaque. It now consists of mucus and pus and an abundant crop of epithelium. Children are so slow in learning to expectorate that when under four or five years of age the sputa are generally raised to the throat and swallowed.

Auscultation at this time of free discharge discovers coarse, moist râles with both respiratory movements. The sense of constriction across the chest has been relieved by the exudation, and the cough ceases to be painful. There has probably been at first a little fever, with lassitude, and some lessening of appetite. These symptoms may last for three or four or even ten days, when the cough and discharge begin to diminish, and there is a speedy return to health. This is a true bronchial catarrh, and, in strict speech, should not, perhaps, be called a bronchitis, for it is doubtful if the mucous membrane is more than hyperæmic.

Not all cases are thus benign. The bronchial tree has numerous branches of many sizes, and the above description applies to a condition in which only the larger ones are involved. If the inflammation dips down into those of smaller calibre, the disease becomes more severe and dangerous; or, if it extends still further, and invades the ultimate twigs—capillary bronchitis—the situation becomes, to the last degree, painful and desperate. Occurring secondarily to other diseases, or in weakly children, bronchitis is apt to be severe, and in young infants even the simplest bronchial catarrh is liable to dangerous and fatal extension.

In the severer forms, the symptoms are pronounced and unmistakable. The cough is frequent and painful. There is dyspnœa, more or less distressing according to the extent of the inflammation and the age of the child. The nursling suffers most, because it must so often relinquish its hold of the nipple to recover its breath. The call for air may be so urgent that all the muscles auxiliary to respiration are actively at work. The inspirations may mount to sixty, eighty, or even one hundred a minute.

The fever, though considerable, is of varying intensity, and you will often notice, as in many other febrile states, a morning remission and an afternoon or evening increase. The relation in frequency of the pulse to the respiration is apt to be changed. Normally there are three or four pulse-beats to one breath. In capillary bronchitis the ratio may be two to one, or even less. So great a change is indicative of extreme peril.

There is great restlessness, as is always the case when the want of air is urgently felt. Secretion, when established, is usually abundant, and auscultation reveals numerous moist râles, both large and subcrepitant. They may also be detected by palpation almost as readily as by the ear. They are especially numerous below and posteriorly, for to these parts of the chest the fluid tends by gravitation. The percussion note is resonant, unless obstruction of bronchial tubes has occasioned pulmonary collapse, or a considerable portion of lung substance has been invaded by the inflammation. Probably in the young child instances of serious bronchitis are rare in which the inflammation is strictly confined to the tubes. Often small circumscribed portions of pulmonary tissue are found to have been inflamed, but the condition is not easy of detection during life.

If the disease continues and extends, other symptoms declare themselves. An inflammation involving the smallest tubes of both lungs cannot long exist without causing marked disturbance of the circulation. Though

the inspirations are ever so frequent, too little air passes through the diminished calibre of the bronchioles to supply the increasing want. The pulmonary vessels refuse free circuit to unoxygenated blood, and the right heart and all the venous system become surcharged. The lips and extremities grow livid, the face takes on a bluish pallor, the temperature falls, and a cold sweat stands on the head, and perhaps covers the general surface. Soon there are marked signs of carbonic acid poisoning. The cough, hitherto so troublesome, abates; the restlessness gives place to quiet indifference; the respirations grow more frequent and shallow; the pulse becomes reduced to a flutter, and then disappears; coma usually and convulsions occasionally precede death.

Such is the course and frequent termination of capillary bronchitis. It is not always fatal. You will meet with cases—not very often, it is true—where the outlook for a time is dismal enough, that do at length recover. A lessening of the dyspnœa is one of the earliest signs of amendment. The disease seldom lasts as an acute affection longer than two weeks. In young infants it has been known to be fatal within forty-eight hours. The return to health after a severe attack is apt to be interrupted by frequent backslidings, especially in cold and changeable weather. It may even degenerate into a chronic bronchial catarrh. Children who have a trend toward phthisis, or are otherwise in delicate health, are liable to this form.

A word or two as to the post-mortem appearances in case of death. There will be redness and swelling, and probably softening of the bronchial mucous membrane. It may look and feel like scarlet-red velvet, owing to intense hyperæmia. These appearances will, of course, be coextensive with the antecedent inflammation. The smaller tubes may be found filled with the muco-purulent exudation that before death gave rise to such distressing dyspnœa and abundant moist râles. If you make pressure upon a cut section, you may observe a drop of this fluid starting from every tube. Very likely you may meet, along the free borders of the lungs, patches of collapsed tissue, for bronchitis is one of the most frequent causes of acquired atelectasis. Frequently, and especially in the lower lobes, you will come across isolated patches of lobular pneumonia, too small to have been detected during life.

Treatment.—A simple bronchial catarrh or "cold on the lungs" calls for little treatment. It is rather for what it may become than for what it now is that it is worth a careful looking after.

Probably an emetic given as soon as the child begins to cough would bring many cases to an abrupt end. We are not often consulted early enough for that. While the cough is yet tight and painful, I try to hasten the coming of the stage of secretion by giving an expectorant as follows:

℞.—Pulv. Ipecacuanhæ, . . . grs. vij
Pulv. Ext. Glycyrrhizæ, . . grs. iij
Sacchari Albi, ... ʒiss
Aquæ, ... ʒiij—M.

Signa.—A teaspoonful every second or third hour; if it nauseates, give less.

When the patient is robust, and more than three or four years of age, I often add to the above .06 grm. or one grain of tartar emetic. Another good plan for children of this age and habit is to give from three to six drops each of wine of ipecac and wine of antimony, with a teaspoonful of sugared water. If restless and feverish, I order a hot foot-bath at bed-time, and give—

℞.—Pulv. Doveri, ... gr. ½-j
Pulv. Ipecacuanhæ, . . . gr. ½
Sacchari Albi, ... grs. xv—M.

I think it well to get the derivative effect of a laxative, as castor oil; or—

℞.—Pulv. Rhei,
Hyd. cum Magnesiæ, . . . āā grs. ij.

Signa.—Ft. chart.

Repeat after a few hours if necessary.

The patient should be kept in-doors at least until the cough is loose and painless. In most instances, from two to five or six days of such care will be all that is necessary.

But if the attack is more severe, as shown by dyspnœa and high fever, there is occasion for more watchful care and more vigorous treatment. The air of the apartments should be evenly moist and warm. As an expectorant, the first formula above given will answer, or something like the following will serve you well:

℞.—Syr. Ipecacuanhæ, . . . ʒvj
Syr. Scillæ, ... ʒiij
Vini Antimonii, ... ʒij
Syrupi Simp., ... ʒiss
Aqua Menth. Pip., . . . ad. ʒiv—M.

Signa.—A teaspoonful once in three or four hours.

If the child is delicate, or under two years of age you had best omit the antimonial wine.

Applications to the chest make an important part of the treatment. Nothing suits me so well as a poultice made of ground mustard and flaxseed in the proportion of one part of the former to from eight to fifteen parts of the latter; stir this into a paste with warm water; spread evenly and not too thickly on muslin; cover this with a thinner cloth and stitch around the edges. This may be long enough to go around the chest, and wide enough to reach from clavicle to umbilicus. Surround this with a layer of oiled silk or other impervious fabric. This poultice should be worn for hours; if too irritating for this, the mustard should be reduced to the point of tolerance. With some thin-skinned young infants you may find it best to leave out the mustard altogether. Indeed, the oil-silk jacket alone will often serve you a good purpose.

Henoch, a recent German author, surrounds the chest with a cloth wrung from cool water, a layer of cotton batting and an oil-silk covering. He advises a renewal of this dressing so often as every half hour if there is much fever; or once in an hour or two if the fever is inconsiderable.

While my preference is for the mustard and flaxseed, it must be conceded that the frequent changing of the cool water dressing would tend to prevent pulmonary collapse by compelling deep inspirations.

Some authors, recent as well as old, counsel dry-cupping of the chest, I am not averse to this practice, but am of the opinion that we have a more effective derivative and counter-irritant in the above applications, because they act on a much larger surface.

After secretion is established, it is apt very soon to become super-abundant. The loosening mixtures prescribed at first are henceforth out of place. The medicines from which we may now derive the most benefit are of those known as stimulating expectorants. One of the best of these is carbonate of ammonium. The following is a pretty efficient combination:

℞.—Ammoniæ Carb., ... grs. xxx
Syrupi Senegæ,
Tinct. Opii Camph., ... āā ʒss
Syrupi Tolutani Bals., . . . ʒiss
Aquæ, ... ad. ʒiv—M.

Signa.—A teaspoonful every third or fourth hour to a child of one year.

I would have you remember that these stimulating expectorants are not admissible during the first stage

of bronchitis. If given before secretion is free they can do no good but may do harm.

When there is troublesome dyspnœa from accumulating secretion, you may secure prompt, though too often but transient, relief from an emetic. For this I have always resorted to ipecac; there are other drugs as good. By all means avoid powerful depressants like antimony.

If late in the disease there are signs of carbonic acid poisoning, be chary of emetics, as they usually fail to act, and add to the prostration. In this condition Dr. Day, an English authority on children's diseases, advises chloroform with ammonia; here is his formula:

℞.—Ammoniæ Carb., . . . grs. iv
Chloroformi, ... ♏xx
Syr. Bals. Tolutani, . . . ʒss
Aquæ, ... ad. ʒij—M.
Sig.—A teaspoonful for a child of one year.

Though opiates are to be used warily in acute bronchitis, they are occasionally necessary. I have seen a single grain of Dover's powder, coupled with a warm foot-bath, carry a two, three, or four years old child from a state of extreme restlessness to one of comparative comfort and repose. But when secretion is abundant and the dyspnœa considerable, you will have a care not to induce a profound or a prolonged sleep by opium or other narcotic.

Do not allow your youthful zeal for medication to cause you to forget the importance of proper support. In severe cases, with labored breathing, strength is lost rapidly unless the nutritive processes are kept active. Give milk or animal broths often, and give stimulants. Infants, like aged people, bear well, and often need stimulants in acute diseases.

Furthermore, in bronchitis a frequent change of position is not only allowable, it is necessary. Do not attempt to keep the infant on its back, for thus the secretion gravitates to the posterior parts of the lungs, and stays there. But change frequently, as, indeed, the instincts of the little one prompt it to do for itself. Lying on the stomach across the nurse's lap is a posture especially favorable to the gravitation of the discharge towards the mouth.

When a child has a chronic bronchial affection the first step towards its successful treatment is to ascertain the cause. If you find it to be syphilis, or scrofula, or tuberculosis, you will shape your treatment accordingly. An occasional emetic does good by clearing the tubes and stimulating them to a healthy activity. Steam inhalations, suitably medicated, and stimulant embrocations to the chest are of service.

℞.—Lin. Saponis, ... ʒiij
Tinct. Capsic., ... ʒiiss
Aqua Ammoniæ, ... ʒiv—M.
Signa.—Apply daily to the chest, with friction. For many cases cod-liver oil is a prime remedy.

In some children, one cold follows so closely on the heels of another that the bronchial tubes are seldom free. This tendency to cold-taking may be overcome by daily exercise out of doors without any extra wrapping of neck and chest, and a cold sponge-bath nightly at bed time. Some cases of chronic weakness and catarrh of the breathing tubes are surprisingly bettered by a change of residence.

ORIGINAL ARTICLES.

IRRIGATION OF THE COLON.

BY CHARLES W. DULLES, M.D.,
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As we are now getting into that season when diseases of the intestines carry off the greatest number of victims, I desire to call attention to a method of treating inflammations of the colon, which has never—as far as I know—been at all generally adopted or even understood in this country; although it is not uncommonly practised in Europe. It is not difficult or dangerous; on the contrary, it is simple and easy to carry out, and it cannot possibly do harm. The method was called by Dr. Alois Monti, of Vienna, whom I saw practice it often in 1876 and 1877, "irrigation of the large intestine."

It is carried out in the following manner: The patient being placed on the side, or back, or with the belly downwards, and the pelvis a little elevated, a large, moderately flexible catheter, if for an infant or a child—or a stomach tube, if for an adult—is inserted into the rectum. To this is attached, by a tube, a reservoir of water,[1] the height of which can be varied as may be required.

The water is now allowed to flow from a height of about two feet until the rectum is distended; meanwhile the end of the catheter or tube in the rectum is pressed gently but steadily upward toward the left iliac fossa. Very soon it will be found that the water has opened out the folds of the bowel and straightened the curves, so that the tube finds its way beyond the sigmoid flexure and into the descending colon. Unless the operator be very unskilful it may now be pushed gently on, the flow of water continuing without interruption, until it reaches the left hypochondrium, when the transverse colon becomes the descending.

The flow of water is now to be continued until the whole colon, all the way to the cæcum, has been gently distended; the operator assuring himself of this by the amount of fluid used, and by palpation and percussion. The tube is now withdrawn and the operation is complete.

The fluid remains in the bowel a variable length of time. Sometimes it begins to come away in a few minutes: but it sometimes remains a half an hour or more.

This method I have seen used by Monti, for various inflammatory disorders of the large intestine, as well as to cause expulsion of worms and flatus; and I have myself used it a number of times with results calculated to give me great faith in its usefulness.

The most striking case, I now recall, occurred in 1878, when I was summoned in the night to an infant a few months old, whom I found screaming and struggling with the pains of acute colitis. I took it on my knee, had cool water and a fountain syringe brought, attached the silver catheter from my pocket case, oiled it and slipped it first into the rectum and then up to the bend of the colon, and allowed about a pint and a half of water to flow in at that point. As the water filled the bowel the child's struggles and cries ceased, and it actually went to sleep before I was done, and only waked when the water began to be discharged.

Such striking results cannot be considered the rule, of course; but there can be no doubt that so complete a lavement must be of advantage in

[1] A fountain syringe or any of its substitutes serves this purpose well.

soothing the angry lining of the bowel and diluting and bringing away both the cause and the products of irritation.

To fill in the outlines of the method a little, I will add that in general the fluid used should be cool, not cold, water. It is rarely necessary to use astringents. When they are desired, the best is alum, in a one or two per cent. solution, with perhaps a few drops of laudanum added. The irrigations may be frequently repeated; and, in cases that do not get well promptly, various temperatures may be tried—from 70° or 80° to 40° Fahr.—depending on circumstances.

The amount of fluid to be used varies with the age of the patient. It should always be enough to fill the *entire* colon. An unweaned infant may require more than two pints, an adult several quarts.

No real syringe should be used if hydrostatic pressure can be obtained; though, if this is not to be had, I have found the syringe, carefully and slowly used, will serve very well.

Thus far I have referred mainly to such intestinal troubles as are most frequent in summer. The method is, I think, invaluable in all inflammatory affections of the colon, from diarrhœa to dysentery, and useful—for reasons I can not go into now—in inflammation of the small intestine also.

Before leaving the subject, I want to speak of another use which I learned by experience last winter. I was called into the country to see a child about two years old, whom I found in convulsions. The use of revulsives had been tried without effect. I could get nothing into its mouth to produce vomiting or catharsis. The means at hand were very limited. I was satisfied from the history that the convulsions were due to irritating ingesta. I concluded to see if they were in the colon. So I took my silver catheter, attached it to a syringe, passed it through the anus, distended the rectum, pushed the catheter up till I could feel it through the abdominal wall, just below the left costal cartilage, and filled the whole colon with warm water, in which a little soap had been stirred. After about three minutes, the water came away and brought a mass of undigested and indigestible stuff that was quite sufficient to cause the trouble. The convulsions stopped, and the child got quite well.

From this case, I think, a useful hint may be gathered, and I am sure I shall repeat my experiment the next time I have to treat a case of convulsions due to intestinal irritation.

I recall attention to this method because I think it too valuable to be allowed to be forgotten; and I hope that it may prove a helpful adjunct to our other therapeutic resources against intestinal disorders.

ON THE PROPHYLAXIS OF PUERPERAL FEVER.[1]

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WITHIN the past few months quite a number of parturient women, many of whom were attended by midwives, or by physicians with but a limited obstetric experience, have died in this city in consequence of the diseases generally comprised under the name of "childbed or puerperal fever," who, in my opinion, could have been saved had the proper prophylactic and remedial agents been used in time, in accordance with the views published by Prof. Carl v. Braun, of Vienna; Barnes, of London; Prof. Fordyce Barker, of this city, and many other well-known authorities, both here and abroad, too numerous to mention, who have made the subject under consideration their special study.

My own experience in the art and science of obstetrics, extending now over a period of more than a quarter of a century, obtained as early as 1855, in the lying-in wards of the University of Pesth, in Hungary, under the late Prof. Semmelweis, and having been quite extensive, I deem it in the interest of science to publish it, with a view of calling the attention of the profession to the fact, as will be proved by a few statistical quotations from lying-in wards abroad, that the death-rate from puerperal fever can be diminished to a minimum—hardly one per cent.—if the measures which I will enumerate further on be adopted for the prevention and the cure of puerperal fever.

Already as early as 1847, Prof. Semmelweis, then of Vienna, enunciated the now well-known fact that puerperal fever, so called, was caused by a contagious or infectious *materies morbi*, communicated to parturient or pregnant women by the hands or instruments of accoucheurs, midwives, or nurses; especially was this the case in lying-in institutions, causing, according to Kiwish, a death-rate of eighty per cent. from septic pyæmia. Up to the time mentioned, the various febrile diseases affecting women during the puerperal state were termed by Cruveilhier and others "hospital fevers." Semmelweis maintained that the cause of these fevers was not to be ascribed solely to confinements taking place in hospitals or lying-in institutions, but that the septic material was often brought into these institutions from without, from dissecting-rooms, or from patients who had been suffering from infectious diseases. Semmelweis proved his assertion by experiments upon rabbits and other animals, upon whom he produced pyæmia and septicæmia by introducing into their genitals decomposed putrid matter, obtained from the bodies of persons who had died from infectious or septic diseases; and, again, he demonstrated that one animal thus inoculated and infected, was, in its turn, a source of infection, producing the same fatal results in other animals, either during the latter part of their pregnancies, or after having given birth to their young.

Hausmann's experiments, in 1868, instituted upon rabbits, by injecting fluid taken from a cadaver where death resulted from infectious peritonitis, inevitably caused the death of the pregnant animals, even if their genital tracts were uninjured, provided, however, the experiment was instituted shortly before or soon after labor—nay, even the injection of healthy pus into the genitals of female animals, at the time mentioned, if their vaginal or the mucous membranes of the uterus were wounded or injured,

[1] Read before the Obstetric Section of the New York Academy of Medicine.

caused always pyæmia and death; but the effect was negative if pus, serum, or blood was thus injected upon the genital mucous membranes of unimpregnated animals. Not every septic fluid produced ill-effects upon the uninjured mucosa of the unimpregnated animals, but it was, on the contrary, inevitably followed by a fatal result if applied in cases of uninjured genitals shortly before or during labor, thus showing conclusively the great susceptibility to infection with consequent fatal results during the advanced pregnant or the puerperal state.

Childbed fever attacks the wealthiest as well as the poorest women. It attacks child-bearing women of all ages, and of varying constitutions, especially those suffering from primary endometritis and vaginitis during pregnancy, who are then liable to parenchymatous metritis and metrophlebitis after childbirth. The catarrhal secretions, according to Braun, often cause catarrhal ulcerations of the denuded mucosa, which then becomes the gate of infection and the starting-point of phlegmonous inflammations. Some cases of puerperal fever undoubtedly originate from the absorption of the foul stuff of decomposition from retained blood-clots, portions of undelivered placenta, the membranes, purulent matter formed in utero, or from wounds or bruises, and subsequent gangrene of the tissues of the genital tract, where the puerpera takes the poisons of her own making, especially in cases of tedious or instrumental labors, which Barnes appropriately terms autosepsis, self-empoisonement; but by far more frequently do we find puerperal septicæmia caused by the introduction of septic matter from without, called by the same authority "exosepsis," in his article on antiseptic midwifery in the January number of the *American Journal of Obstetrics* of this year.

Primiparæ, especially older persons, are oftener attacked than pluriparæ, especially during the winter months, when not only its frequency, but, at the same time, the mortality is greatly augmented. In winter, erysipelas, phlegmonous and catarrhal affections of the cellular tissues and the respiratory tract occur oftener than at other seasons of the year, so that, for the same reason, inflammations of the genitals during the puerperal state are often the products of the same influences.

The death-rate from puerperal fever is far greater than from small-pox. From the latter only 3 persons died out of every 100,000 inhabitants in 1875, since the law of compulsory vaccination had been enforced in Prussia, while in the same year 39 per 100,000 inhabitants died there from childbed fever.

A commission appointed, in 1878, by the German Government to investigate this subject ascertained the fact, in addition to what I already quoted above regarding mortality, that 8872 women die annually in Prussia of puerperal diseases without being in all cases the consequences of difficult or dangerous, but often of easy and natural, labors. During the year mentioned 60,209 women, who were under fifty years of age, died from all diseases; of these, 12.09 per cent. lost their lives from puerperal fever in the country mentioned.

One of the most frequent causes of the diseases during the puerperal state, as reported by the same authority, fully confirmed Semmelweis's views above referred to, viz., that many otherwise healthy women who were attacked by puerperal fever were beyond doubt proved to have been infected by one and the same attendant, even if the labors were natural ones. This view of the possibility and transmissibility of the puerperal-fever poison is shared by Schroeder, M. Boehr, Fassbender, H. Martin, Lochlein, and many other authorities.

I am acquainted with a physician, who some years ago lost quite a number of patients, who died of puerperal fever—septic or pyæmic—while under his care. Being followed by such ill luck, he finally left this city and went abroad for a time, to avoid being the direct and, of course, the involuntary cause of any more deaths among his patients.

Nearly 500 women in the prime of life, lose their lives annually, in this city, from eclampsia parturientium et puerperarum, puerperal peritonitis, metrophlebitis, pyæmia, or lymphangitis. In Vienna, "Allgemeines Krankenhaus," from 1834 to 1848, of 39,156 women delivered, 3,486 died; from 1849 to 1863, 61,170 births and only 998 deaths; from 1863 to 1878, 61,949 deliveries and only 825 deaths from puerperal fever. In 46 years, of 162,275 women (of these, nearly 100,000 were delivered under the supervision of Carl Braun), 5,309 died of childbed fever. By examining these interesting figures as published by Braun, I was convinced of the fact, not generally known, that before Semmelweis's teachings had been heeded the mortality in the Vienna lying-in institution ranged, annually, between 5 and 10 per cent. and over; while since the precautionary measures which I will presently enumerate were adopted, the death-rate never exceeded 1.3 to 2.5 per cent.

These means, as practised in Vienna, I have myself adopted and applied during my practice of obstetrics, and I am able to state that I have never had the misfortune of losing a single case in my own practice from puerperal fever.

This good luck I do not claim as being due entirely to good management on my part. It will be impossible, as far as our present knowledge is concerned, to prevent the occasional occurrence of puerperal fever under the best hygenic, dietetic, medical, and surgical treatment, but I maintain without fear of contradiction that we can reduce its percentage, and are able to prevent the spread of the infection from one parturient to others who are healthy at the time of labor, and even after tedious instrumental deliveries we may save many lives which would otherwise be inevitably lost.

The prophylactic measures are briefly the following: The hands of every attendant should be carefully cleansed and disinfected with a 3 per cent. watery solution of carbolic acid or other disinfectant, and afterwards oiled with carbolized oil of the same strength, before examining the genitals of the parturient or pregnant woman; for the removal of the bad odors from the hands, a one-half per cent. solution of permanganate of potash is used; for the black stains caused by it, a 10 per cent. watery solution of dilute hydrochloric acid is applied until the

hands become bleached. The bowels of the parturient should in all cases be moved by an enema of white Castile soapsuds, a whole basinful, with one or two tablespoonfuls of melted lard; the water should be drawn if necessary by a catheter (soft rubber, Nélaton's) which has been thoroughly cleansed and disinfected. The hand should never be introduced into the uterine cavity in natural labor. The vagina and vulva to be disinfected with a lukewarm watery solution of thymol or salicylic acid, 1 part to 1000 aq., with the addition of 3½ parts of glycerine and 7½ of alcohol, in case the thymol be preferred. This cleansing injection is to be used in every case of labor before parturition, but after delivery injections are only found to be useful after difficult operations, very tedious, protracted deliveries, especially after the artificial separation of the placenta, internal version. The uterine cavity is washed out in these cases preferably by a fountain syringe to which a flexible, well-cleansed, and disinfected rubber tube is attached.

The thymol or salicylic acid, lukewarm, of the strength mentioned, is safer than carbolized water. The solution is allowed to flow into the cavity with the least pressure, and in sufficient quantity, from one to two or more quarts at a time, until the water returns free from shreds, blood, mucus, etc., and has only the odor of the thymol; whenever the lochia become in the least offensive, the injections are to be repeated. I have used them in cases of the artificial separation and removal of the placenta, etc., with the happiest results, from six to eight times during twenty-four hours. Slight lacerations of the perineum, or wounds made by episiotomy, are closely united by serre-fines, or, if extensive, by metallic sutures; bruised wounds of the vagina should be pencilled with pure tincture of iodine, muriated tincture of iron, thymolized oil, or, according to Fehling, with salicylic powder (one to five of starch) applied two or three times a day. Under this treatment, they usually heal in from three to five days.

Free ventilation, and the utmost cleanliness in and about the lying-in room, *cannot* be substituted by any amount of disinfection. The thorough disinfection of the utensils, the bedding, and all instruments in use ought rigidly be insisted upon; all emotions are to be scrupulously guarded against: the secretory and excretory organs of the patients should be kept in as healthy a condition as possible. Chilliness of the patient should be carefully obviated, and the thermometer used twice daily in the well-dried axilla of the patient. The child is applied to the mother's breasts about two hours after delivery, as soon as she has had some rest, and no tea or other food allowed the new-born except a teaspoonful or so of sugar water in very hot weather. The care of the mother's breast deserves special attention, since fissures, eczema of the nipple, often cause pain, nervous excitement, restlessness, and often fever. Cold applications—tannin and glycerine, slight touching with nitrate of silver or Peruvian bark 4, to 8 of almond oil, 6 of mucilage of gum arabic, and 35 of rosewater, applied every hour, will heal sore nipples in a few days.

To obviate hemorrhage post-partum, is to oppose septicæmia, says Barnes, justly. I therefore always give 4 grammes (3j) of fluid extract of ergot (Squibb's or Wyeth's), even in natural labor after its completion, and repeat the dose, given in sugar water, until the uterus has firmly contracted, and it becomes evident that no portion of the placenta, the membranes, or of blood has remained in the vagina or the uterus. The least hemorrhage from the genitals is treated by tincture of iodine, persulphate of iron, hot-water injections, the silver wire, or carbolized silk ligature. Contrary to the teachings of the Vienna School, I apply the abdominal binder and a pad or napkin over the uterus. This practice, also recommended by Barnes, tends to aid in contracting the uterus, and, moreover, counteracts the suction or aspiration force and the entrance of air into the genitals, one of the factors of putrefaction. I differ, however, from Barnes, as being unnecessary, to make intra-uterine carbolized injections, 2 per cent. solution once or twice daily from the second day, or even after natural delivery. I use injections only when the lochia are offensive. I deem it superfluous, and even dangerous, to use vaginal or intra-uterine injections after natural labor, unless indicated as stated above. If fever symptoms appear, as shown by the thermometer placed in the axilla, I also syringe the vagina several times a day, but not otherwise. The intra-uterine injections are used in puerperal fever with great benefit, still, in Germany, there are more opponents to, than advocates of, intra-uterine injections; they prefer drainage tubes of soft rubber in suitable cases. Before draining the uterine cavity, or making injections into the same, the straightening of the ante- or retroflexed uterus has to be resorted to, otherwise these means cannot be usefully applied. Frankenhauser (1879) considers the prophylactic intra-uterine injections post-partum the cause of many unfavorable terminations, especially as the cause of a considerable rise in the temperature. He justly says we run the risk of thereby introducing air, and are never sure of washing away all the putrefying material from the uterine mucosa. He objects to intra-uterine injections, as well as the introduction of the hand into the uterus, unless absolutely unavoidable. If the latter becomes necessary, he does it under the carbolic spray. He even examines all his patients before, during, and after labor under the carbolic spray. Salicylic water injections are also sometimes followed by evil consequences. He says: "I have had no untoward symptoms from intra-uterine injections with salicylic water in cases where I had to introduce the hand into the uterus for adherent placenta, turning, atony, and post-partum hemorrhage; but I object to the indiscriminate use of disinfectant solutions after normal labor as an unnecessary and meddlesome procedure."

Many cases of child-bed fever being caused by the infection from one case to others, the immediate isolation seems as imperative as if it were a case of cholera or small-pox.

This precaution is now rigidly carried out in all lying-in institutions with the happiest results, as detailed by Tarnier at the last International Congress held in London. Its quotation may be of use to those who are not familiar with this excellent

method. He says, "Even in 1856, when I was Interne at the Maternité Hospital, the mortality was five per cent., this was now reduced to two per cent. in hospital and three-quarters of one per cent. in the pavilion I had constructed a few years ago. Each patient there has a separate room, entered from without, so that a nurse can only pass from one to another by going outside into the open air. The furniture is of japanned iron, the floors, walls, ceilings are of impermeable concrete. The mattresses and pillows are stuffed with cut chaff, which is burnt after use in every single case. Instead of McIntosh sheets, one of brown paper, made impermeable by pitch, is used; this is burnt after use." For the washing of the genitals, he uses weak solutions of bichloride of mercury, as being the best and most powerful germicide.

Dr. Fancourt Barnes, in the British Lying-in Hospital, delivered all his patients under the carbolic spray. All washings, syringings, and examinations are done with carbolic solution; spray (1 to 80 aq.) is continually playing in the ward. To secure uterine contraction, each patient has a mixture of quinia, ergot, and opium, three times a day, for the first week. Since instituting this treatment, he rarely finds it necessary to use intra-uterine injections, and only exceptionally finds any rise in the temperature during the lying-in. I deem the proper prophylactic measures of disinfecting the utensils, the air, the hands, the instruments in and about the lying-in room, of the utmost importance, and I have quoted, at length, authorities in support of the correctness of this practice, the more so, since a short time ago I read, in the *New York Herald*, a lecture by Prof. Chandler, of the New York Health Board, who asserted that money spent for carbolic acid was practically wasted. He says it does not kill germs of disease! Sacicylic acid, thymol, permanganate of potash, *bichloride of mercury*, and in fact all the chlorides and sulphates, etc., will kill vermin, and destroy animal and vegetable life if used in sufficiently large quantities, and even by its moderate, non-poisonous application, we can surely prevent putrefaction by the agents mentioned, as proved by the microscope. If, for instance, the bacteria and micrococcus of diphtheria be examined with a magnifying power of, say, five hundred diameters, they are seen jumping and dancing helter-skelter on the stage within the visual field, and if the same bit of membrane showing these organisms be placed in a solution of carbolic acid, they soon die and show no sign of life at all. It is true, we have only the means at our command to prevent putrefactive changes; if these have once taken place, we have no agents which will restore the putrefied substance to its former healthy condition.

Antiseptic surgery and also antiseptic midwifery have already stood the test of time as to their high value, and we need not fear that as preventive, though not as curative, agents against infectious diseases, these will ever be found wanting.

Rest after delivery in the recumbent posture with the head and shoulders raised, for the purpose of aiding uterine drainage, for at least eight or nine days, should in every case be insisted upon. Many women in this city delivered by uneducated, ignorant midwives, especially among our foreign population, are poisoned and often killed by having the infection brought to them by their attendants, whom I have often found to neglect the necessary cleanliness and ventilation of the lying-in room. Soiled clothing, urinals half or quite full of decomposing urine, fecal matter, and lochial discharges, left there for hours, no doubt become the foci of puerperal-fever poison. All midwives should, therefore, have a license from the city or State authorities before being allowed to attend confinement cases, and should be examined as to their fitness for assuming the great responsibility during the agonies of the parturient, often victimized, woman. The licensed midwife should be furnished with printed rules by the health authorities, similar to those recommended in 1878 by the puerperal fever commission, viz., that in confinements the putrefaction of the secretions of the mother be prevented; that the labor be terminated before there is any offensive discharge from the vagina; that the causes of putrefaction, the cocco-bacteria, be destroyed by thorough disinfection; that all the attendants be instructed to use disinfectant vaginal injections in all protracted and tedious labors, and to disinfect their hands in all cases before making a vaginal examination; to report to the sanitary authorities every case of puerperal fever occurring in their practice; that puerperal fever be classed among the infectious and contagious diseases; that the authorities be notified even of the occurrence of every case of high fever during or after childbirth.

To prevent the spread of puerperal fever, midwives, unless licensed, should not be allowed to attend confinement cases, making such attendance punishable by a fine and imprisonment. Every attendant should carry a two per cent. solution of carbolic acid to every labor case. Instead of diapers or sheets, carbolized cotton, tow or oakum should be used under the genitals to receive the lochial discharges, and be burned before becoming offensive. Among tenement-house occupants, I have often noticed the throwing of the after-birth into the privies and water-closets, where they decompose and are the cause of many infectious diseases. The health laws in this country say nothing regarding the disposal of the after-birth, which should be burned or buried in every case. Baths are thought to be injurious during confinement and even during pregnancy, not only by the laity, but also by many physicians. If the parturient can be conveniently lifted into a bath-tub and immersed for a few minutes in it and removed to her bed without the least exertion on her part, I know of no preventive measure against puerperal fever which surpasses its utility. If these means were generally carried out, a very small percentage of women would die from childbed fever—especially after natural labor.

CASE OF INTESTINAL OCCLUSION.

BY L. D. WILSON, M.D.,
OF WHEELING, WEST VA.

OBSTRUCTION of the bowels, while by no means rare, possesses features of peculiar and striking interest. The generally sudden onset; the usually previous good health of the person attacked; the extreme distress and suffering accompanying it; and the almost certain and speedy death to which the sufferer is doomed, all combine to excite the liveliest emotions of sympathy; while the paucity and, for the most part, the inadequacy of our remedial resources are the occasion of many melancholy reflections. The difficulty of determining in a given case either the seat or the cause of the difficulty is in most instances perplexing in the extreme; and the treatment, instead of being based on a rational consideration of the actual conditions present, is forced to take counsel of doubt and conjecture. To carefully and succinctly note the symptoms and pathology of every case that may differ in either respect, no matter how minutely, from those which are already understood, is the only way in which our knowledge as respects diagnosis can be widened; and this must furnish the excuse for presenting the following case:

CASE.—On the afternoon of May 6, 1882, I was called to see C. F., a widow, aged sixty-five, of spare habit, and somewhat broken by age. She was complaining of a severe pain in the left hip, which had come on suddenly during physical exertion, and which seemed to extend from thence across the lower portion of the abdomen just over the region of the bladder, until it almost reached the opposite side. There had previously existed considerable lameness in the left leg, the origin of which I was not able to learn, except that the leg was affected about the time of the menopause, some fifteen years before. She ascribed this lameness to "change of life, which," as she expressed it, "had settled in the hip." There was stated to be some shortening of the limb, and also that at various times in the past she had suffered from attacks of pain similar to the present, except that in the previous attacks the pain seemed to be limited to the hip and limb. These preceding attacks of pain always seemed to be caused by some unusual exertion or fatigue, and this last attack was ascribed to the same cause, as she had been, for several days before, much more actively engaged than usual in household duties. She had also been troubled for many years with frequently recurring colicky pains in the lower part of the abdomen, and the stomach and bowels would almost daily be more or less distended with gas, giving rise to frequent eructations. Her appetite had long been poor, and the bowels alternately constipated and relaxed, and latterly she had been oppressed by a gradually increasing feeling of weariness and fatigue. After a day of unusual exertion, as before stated, and while still at her work, she was seized with this sudden pain, which was soon followed by vomiting. An examination developed the following condition. There was marked tenderness on pressure over the region of the bladder; some fulness of the abdomen, but neither hardness nor tenseness on manipulation, and no indications of any tumor or enlargement of the viscera. The pulse was full and regular, and but little accelerated; the tongue very slightly furred, and moist; and the skin slightly yellow. There was no headache; the temperature seemed to be normal—no record of it was taken, however—there was no disturbance of breathing, and the mind was perfectly clear. The bowels had not acted on this day, but there had been a slight motion on the day before. Owing to her evident suffering, and desire for speedy relief, no special investigation of the condition of the limb was undertaken for the present, especially as she was used to such attacks, and a hypodermic injection of morphia was given over the left hip, and a morphia mixture ordered at intervals until pain should be relieved, after which a mild cathartic was directed to be given. At the visit the next morning it was found that the pain in the hip had been almost completely relieved; the tenderness over the lower part of the abdomen was somewhat less, the fulness and softness remaining unchanged; but there had been frequent vomiting of a bilious character during the night, and the bowels had not been moved. This, of course, excited no surprise, as all the medicine given for that purpose had been thrown up almost as soon as taken. Urine had been passed in moderate quantity; the skin was still natural; and the tongue not changed. On inquiry at this visit, it was learned that she had had a hernia many years before, but that it had never given her any trouble. Examination revealed on the left side the hernial opening, which freely admitted the index finger almost to the second joint, and which seemed to be occupied by a sac, which gave the impression to the finger of being considerably thickened at the depending fundus. This was freely movable; could be readily pushed up as far as the finger could reach; and there was no hardening, pain, tenderness, nor, indeed, any indication of strangulation. As the stomach was quite irritable, all internal medication was suspended, except such as was directed to the relief of this symptom, and hot applications were ordered over the tender region of the abdomen.

On the third morning, the patient was found to be in much the same condition as on the day before, except that the tenderness over the abdomen was very much diminished, but there was rather more fulness; the vomiting had continued, the stomach rejecting everything taken into it. Other measures for the relief of this symptom were directed for the day, and an enema was ordered in addition. The patient was visited again about 5 o'clock P.M., and there was found but little change from her condition in the morning. The tenderness over the abdomen had almost disappeared; but while the abdomen was still soft and pliable, it seemed rather fuller. The pulse was still full and regular, but somewhat accelerated; the skin cool and moist; the tongue moist and velvety. The vomiting had been much less frequent, but there was about the vomited matter, which was of a dark-brownish color, and liquid, a faint fecal odor. She complained, too, that the remedies used to quiet the stomach caused some

oppression about the chest, and, on this account, they had not been regularly continued. The enema had been given, but nothing was brought away. As it was now plain that there was obstruction or strangulation of the bowel at some point, no further efforts were directed to the stomach, but as the patient's general strength seemed but little affected, it was deemed best to give the treatment by enemata a further trial. This was accordingly directed, and instructions given for fully carrying it out. About midnight, I was hastily called, the messenger stating that she was much worse. I saw her shortly afterwards, with Dr. A. F. Stifel, of this city, in consultation. We found her apparently much exhausted; pulse 102, weak and somewhat irregular; skin cool; countenance shrunken; vomiting frequent, and of a very marked stercoraceous character; abdomen somewhat fuller, but still soft, and but slightly tender on pressure. She had been so averse to being disturbed that the directions in regard to the treatment given at my former visit had not been carried out. After a careful examination, it was agreed that the only alternatives remaining to us were either that of persevering with the enemata, or the desperate one of opening the abdominal cavity and attempting to relieve the difficulty by such further procedure as might be indicated. This latter plan was at once rejected by the patient and friends, but, after some persuasion, we were permitted to make a further trial of the former. Accordingly, a rectal examination having revealed nothing, an enema was given, which at once passed away without any result. After waiting half an hour, another was tried, with no better success. As the patient was averse to any further efforts to relieve her, it was, at the suggestion of Dr. Stifel, agreed to put her fully under the influence of opium. Accordingly, one-third grain of morphia was given hypodermically, and she was left for the remainder of the night. At the visit next morning, Dr. Stifel accompanying me, the patient was found more comfortable; had slept during the intervals between the acts of vomiting, which had been much less frequent; the pulse had recovered strength and regularity, and was somewhat less frequent; the abdomen, with the exception of somewhat further increased fulness, was unchanged; skin cool; and the secretion of urine, which had been very scanty the day before, was again moderate in amount. Morphia, one-third grain, was again administered, and the patient left. At the evening visit, she was found to have passed a more comfortable day than at any time since her illness began. The pulse was full, regular, and about 94; skin cool; mind clear, with less mental depression; abdomen yet further enlarged, but still without anything like tenseness or hardness in any part, and but very slightly tender on pressure, the tenderness, as at first, being limited to the lower part. The vomiting, however, still continued. Brandy and water, which had been given frequently in small quantities for the last day or two, although vomited soon after being taken, was directed to be continued; morphia was again given, and, as the patient seemed disposed to allow it, an enema of olive oil was directed. On the next morning, I found the patient dying. Cold, pulseless, shrunken, and wandering in mind. The olive-oil enema had been given without result; but the vomiting had almost entirely ceased during the night. Throughout the entire course of the attack, there had never been any straining or inclination to have a movement of the bowels. Death took place about 11 o'clock A.M., on the fifth day of her illness.

Autopsy.—After some hesitation, a post-mortem examination of the parts chiefly implicated was allowed. This was made about nine hours after death. The body exhibited marked cadaveric rigidity, and the abdomen was much distended. Upon opening the abdominal cavity, and drawing the omentum aside, the coils of the small intestine which first showed themselves were found to be distended with gaseous and dark liquid contents, but there were no adhesions between these distended coils, no deposit of lymph on their serous covering, nor were there any special evidences of congestion. On drawing them aside, the colon was found only moderately distended with air only, neither liquid nor solid matters being noticed. Upon the left side, a prolongation of the omentum was found extending downwards, and upon examination it was found to extend into the hernial sac before mentioned, and to have formed very strong adhesions within it, but there was no stretching or strangulation. The adhesions were so lax that the imprisoned omentum could be easily drawn out as much as two inches before putting them on the stretch, and so large was the ring, that the finger could easily be introduced alongside of the omental prolongation as far as the bottom of the sac. All these manipulations were very carefully and cautiously made so as to disturb the parts as little as possible. Returning to the cæcal region, the appendix vermiformis was found to be unusually long; the ileum at its entrance into the colon was empty and completely collapsed, and on tracing it carefully backwards quite a number of coils, some of them very slightly adhering to each other, were found, and all of them in this empty, corrugated condition. After having traced the ileum in this manner for more than a third of its length, a sharp bend, almost an angle was found, and just before the collapsed portion merged into the angle, it abruptly enlarged and continued as the distended portion from thence to the duodenum and stomach. In contact with this angle or knuckle, another knuckle of the distended portion of the bowel was lying, very much as in the closed fist one finger lies against its fellow, and between them a recent and very slight adhesion had formed, the adherent surfaces not being larger than a gold dollar. Within the angle of the occluded knuckle of intestine was an old cicatrix about one inch in length. This cicatrix had evidently been parallel with the long axis of the bowel, and its contraction had been the means of producing the sharp angle which existed, and also no doubt caused a narrow stricture of the bowel at this point. Surrounding the angular knuckle, and about one inch from its apex, was an indistinct marking, as if caused by the knuckle having been held for a long time against the hernial

ring while slightly protruding through it. At the distal end of the cicatrix, reckoning from the pylorus, and at the point where the adhesion existed, there was moderate inflammatory thickening, evidently recent, of the intestinal coats, and this no doubt converted the stricture from a permeable into an impermeable one. So complete was it that neither liquid nor air could be made to pass through it. No other organs were examined..

Remarks.—In reviewing the history of this case in connection with the autopsy, the first question that arises naturally is—To what cause was the very slight and circumscribed inflammation at the seat of stricture due? The first thought would be that it most probably had been caused by the lodgement in the constriction of some solid substance taken with the ingesta; and this, indeed, may have been the case, but no satisfactory evidence that such had been the case was discovered. Not to multiply surmises, the conclusion arrived at was as follows: That an adhesion between this knuckle of bowel and either the portion of omentum included in the hernial sac, or a part of the hernial ring, had existed for an indefinite period, perhaps from the time the hernial protrusion occurred; that the occasional attacks of pain which had always been referred to the hip and limb, were in reality located at the point where this adhesion existed, and were caused by some dragging or partial laceration of the fibres forming it; that, finally, some unusual strain caused the adherent parts to separate, the rupture of the adhesions exciting just enough inflammation to cause the slight thickening necessary to close up the already narrow passage. This hypothesis seems to fully explain the difference between the final and the previous attacks of pain in the hip. All the previous attacks had been limited to the hip and limb only, while the last one seemed to extend across the abdomen over the region of the bladder, and it was just back of this viscus that the occluded knuckle was found, where it had fallen against another portion of intestine and a slight adhesion between them had formed.

Stricture of the bowels caused by the process of cicatrization is quite rare. In a table of the causes of obstruction in 1547 cases given in Ziemssen, Ency., *Constrictions*, and under this head are grouped chronic kinks, different kinds of stricture, constriction by chronic peritonitis, adhesion, etc., occurred in 106, or about 7 per cent. Of this number, the short time at my disposal prevents any attempt at ascertaining the ratio of cases caused by cicatricial contractions to the other causes grouped under this head, but it must be extremely small. The causes of cicatricial stenosis are but few and of rare occurrence. Healing of dysenteric and tubercular ulcers are the most common, corrosive poisons rarely, and in very rare instances typhoid ulcers (this is much disputed), arrested fecal masses, foreign bodies, separated intussuscepta, syphilitic ulcers, etc. Rare as the cases of stricture of the intestines are, but a very small proportion of them are located in the small intestine. In 100 fatal cases of stricture given by Brinton, only 8 were situated in the small intestine. Bristowe states (Reynolds' Syst. Med.) that "stricture as a cause of death belongs, almost without exception, to the large intestine, and not only so, but at least three-fourths of the total number of strictures are situated below the middle of the transverse colon." This, of course, would be expected when we remember that the few causes of cicatricial stricture of the small intestine, viz.: Tubercular and typhoid ulcers, corrosive poisons, foreign bodies, separated intussuscepta, etc., must very rarely be present. It should also be stated that cicatricial stenoses have been found in both large and small intestine, of which no satisfactory explanation could be furnished. In all the list of causes of intestinal cicatrices, no one is found which seems at all likely to have been concerned in its production in the case under consideration, but that its causation was connected in some way with the hernia there seems little reason to doubt. On account of the very rare occurrence of cicatricial stricture of the small intestine, it might be well, perhaps, to make a comparison of the symptoms observed in this case with those of intestinal obstruction in general, and to note the points of similarity and difference.

1st. *Pain.*—This is one of the most usual symptoms in cases of obstruction. It may, and usually does, partake of the characters both of peritonitis and colic, although either may exist without the other. Painful peristalsis is the cause of much suffering and distress in most cases. The pain in the present case seemed to be altogether that of peritonitis, the actual pain lasting but one day, after that the condition was simply one of tenderness, which steadily and rapidly diminished. As in all cases of chronic stricture of the bowels, this patient was subject to recurring attacks of colicky pain previous to the final symptoms of obstruction, slight indiscretions in diet or undue physical exertion serving to excite them.

2d. *Vomiting* is stated to be "rarely if ever absent in these cases," and it is also thought to come on earlier and to be more persistent and severe, the nearer the lesion is to the stomach; the character of the vomited matters, too, is thought to be much modified by the seat of the occlusion. In this instance the different character of the ejecta followed in the usual order: 1, Contents of the stomach; 2, bilious in character; 3, then rapidly assuming the stercoraceous character. Vomiting usually continues to the last, although, as in the present instance, it may become much less frequent during the last hours.

3. *Constipation* is, however, the most characteristic symptom, and, in complete obstruction must, of necessity, always be present. In permeable strictures, on the other hand, especially when situated in the small intestine, it may not be prominent, and may even alternate with a relaxed condition.

4th. The *abdomen* is almost always more or less distended and tympanitic, but where the occlusion is high up there may be, on the contrary, flattening or retraction. Where the obstruction arises from fecal accumulation, tumors, intussusception, gallstones, etc., the cause may sometimes be recognized by palpation of this region, provided the conditions are favorable. Distention in this case was not

a marked feature, although it slowly and steadily increased, and there was tympanites from the first.

5th. *Urine.*—The condition of the secreting function of the kidneys was at one time thought to furnish an indication of the location of the difficulty. A marked diminution or suppression of the urine was thought to indicate that the lesion was high up, and on the other hand, if it was situated in the lower part of the ileum or in the colon, the urine would probably be normal in quantity. Later observations, however, do not confirm this. In the present case, the obstruction being near the middle of the small intestine, it would be supposed that the urinary secretion would be but little interfered with. In point of fact the urine was somewhat diminished at first, and on the third day it was scanty, but afterwards the quantity increased to a fair amount.

6. *The mode of attack* is a valuable aid to the diagnosis. Strangulation and intussusception are nearly always sudden in their onset; obstruction by gall-stones is almost always preceded by symptoms indicative of their presence; stricture and compression are more likely to be preceded by a train of symptoms such as presented themselves in the case before us, but it is also stated (Ziemssen) that a constriction not unfrequently remains latent for a time, and then suddenly goes on to occlusion.

7. *Prognosis* in these cases is very grave. Life may continue for several weeks, where the obstruction is in the lower colon or rectum. Death occurs more and more rapidly as the lesion approaches the stomach. In any case where enteritis or peritonitis supervenes, death follows rapidly. The average duration of an acute occlusion is given as six days, and varies from eight hours to thirteen days (Ziemssen).

8. *Treatment.*—It is not now proposed to go into a discussion of the subject of treatment. The rules governing the management of these cases are pretty clearly laid down, and in only one respect is there likely to be much variation from the present practice. The recent and brilliant achievements in the field of abdominal surgery force upon us the conviction, that operative procedures will play a much more prominent part in the future management of these cases than heretofore. Of all the causes instrumental in the production of obstruction, one only, viz., fecal accumulation, is in any proper sense amenable to treatment in any other manner. In all the others, palliative and expectant measures are the disappointing alternatives, and a careful consideration of the results attained by these fully warrants the conclusion that in an exploratory operation lies the greatest, and in the vast majority of cases the only, hope of relief.

CASE OF OUTWARD DISLOCATION OF THE RADIUS AND ULNA.

BY JOHN A. SIEBER, M.D.,
OF FERDINAND, INDIANA.

IN a paper on outward dislocation of the radius and ulna, which Dr. D. Johnston read before the Kentucky State Medical Society (see *Louisville Medical Herald*, 1879), he claimed the case he then narrated to be the second reported by an American surgeon. The majority of cases on record are from the French, who quote eleven complete outward dislocations of both bones. Prof. Gross says (*System of Surgery*, vol. ii. p. 144), lateral dislocations of both bones at elbow-joint, besides being extremely rare, can scarcely occur in any other than an incomplete form, and as a consequence of severe injury extensively implicating the soft parts; this undoubtedly is incorrect, as the case which I had under treatment and that reported by Dr. Johnson clearly prove.

The case which I now record is that of a little girl about nine years of age, who was returning home from school on the evening of November 21, 1881, when the accident occurred; it was while crossing a brook over which was placed a round log, and nearing the end she fell a distance of about two feet; the position of her arm while falling I was unable to learn; about two hours after the accident occurred I saw the patient at her home; found her in a sitting posture, crying, with her forearm nearly at right angles and resting the limb on her lap.

I requested the mother of the little patient to remove the sleeve of the dress from the injured arm; when I was astonished at the dimensions of the joint, thinking it impossible to have swelled to such a degree in so short a time; proceeding at once upon an examination, I could find no contusions nor lacerations, nor crepitation, and found that the enlargement was not due to swelling, but to a complete outward dislocation of both bones.

The internal condyle was very prominent, the skin stretched very tensely over it. Externally the olecranon process of the ulna could be distinctly felt with its neighbor, the radius, rotating in the lesser sigmoid cavity; the external condyle was beneath the radius, and required firm pressure to be distinguished; both the biceps and triceps were uncontracted and flaccid, and any attempt at flexion or extension brought forth piercing cries, while pronation and supination were not so seriously interfered with. I requested the father of the little patient to get his conveyance in readiness that we might take her to town, as it was necessary to administer an anæsthetic and also to procure assistance. Accordingly we proceeded to the office of E. J. Kempf, M.D.; here she was placed under the influence of chloroform (Squibb's); the doctor also examined the case very carefully and verified my diagnosis.

As to reduction, it was easily accomplished; grasping the elbow-joint with my left hand, and the wrist with my right, I made extension and gradual flexion; with the hand encircling the joint, the olecranon was pressed inward, and both bones slipped readily into place with the usual soft snapping between the articular surfaces.

The arm was put up in the ordinary dressing with card-board splints, and placed in a sling; the parents instructed to report in a few days, or earlier, should the child complain of pain. The case progressed favorably, and in due course of time the child regained full use of its arm.

HOSPITAL NOTES.

TREATMENT OF FRACTURES OF THE UPPER EXTREMITY IN THE HOSPITALS OF PHILADELPHIA.

(Reported by H. R. WHARTON, M.D.,
SURGEON TO THE CHILDREN'S HOSPITAL, PHILADELPHIA.)

THE treatment of fractures of the humerus, in the hospitals of Philadelphia, presents some variety in dressing depending principally upon the situation of the fracture.

Fractures of the shaft of the humerus are generally treated by first applying a roller bandage to the injured arm, from the tips of the fingers to the shoulder; a binder's board or leather splint is then softened in warm water and moulded to the rotundity of the shoulder; this should be long enough to extend down the arm to a short distance above the condyles, and should include about one-half of the circumference of the arm. An internal angular splint long enough to extend from the axilla to the tips of the fingers is padded with oakum or cotton and applied to the inner surface of the arm, and held in position by a bandage applied from the fingers to the shoulder, which includes the shoulder cap, and may be finished with some spica-of-the-shoulder turns.

To complete the dressing, a sling only is required, which should be so applied as to bring the point of support near the wrist, so that the weight of the tissues between the point of support of the sling and the fracture may exert some extending force.

This dressing is usually changed after twenty-four hours, and subsequent dressings are made less frequently; the dressing is usually dispensed with at the expiration of from four to six weeks, if union has progressed satisfactorily.

For fractures of the humerus high up, that is, at the anatomical neck, upper epiphysis, intracapsular, or of the tuberosities, this dressing is somewhat modified.

The arm is extended and the initial roller, and the binder's board or leather cap of the shoulder, are applied as previously described; a folded towel or a few thicknesses of patented lint are then placed against the chest and the arm is brought firmly to the side of the body, which acts as a splint. The arm is now secured in this position by turns of a bandage which encircle the chest, and extend from the elbow to the shoulder, and the forearm is carried in a sling as previously described.

In fractures about the upper third of the humerus, where the action of the deltoid muscle causes an outward tilting of the lower end of the upper fragment, some difficulty is experienced in maintaining the fragments in line; to correct this, Prof. Agnew recommends that, when the internal angular splint has been applied, the arm should be elevated to bring it to a right angle to the body, with a view of relaxing this muscle, the cap of the shoulder and bandage which secures the dressings to the arm should then be applied while the arm is in this position, and generally serve to prevent a recurrence of the deformity when the arm is dropped to the side and secured in the sling.

Dr. Levis, of the Pennsylvania Hospital, mentions a case in which this displacement was so marked and persistent that the arm was treated in this position for some time, until there was enough union between the fragments to prevent the recurrence of the deformity, when the arm was placed in the usual position.

Fractures of the condyles of the humerus are treated by replacing the fragments by manipulation as far as possible, then applying a roller bandage from the tips of the fingers to the shoulder, with a few figure-of-eight turns about the elbow to allow of flexion for the application of the splint; a well-padded anterior angular splint, extending from a short distance below the shoulder to the tips of the fingers, is next applied and held in position by a roller bandage, and the arm is carried in a sling.

Prof. Agnew, in addition to this dressing, recommends that a leather or binder's board cap extending a few inches above and below the joint be applied to the posterior surface of the elbow; he also in certain cases uses a Stromeyer's splint, so that the angle at which the arm is placed may be changed from day to day without disturbing the dressings, and in all cases insists on early passive motion to prevent stiffness of the joint.

Some surgeons in the treatment of this fracture use the internal angular splint, applied in the same manner as in the dressing for fractures of the shaft of the humerus.

The splint is permanently removed at the expiration of four weeks and the patient is encouraged to use the arm to overcome the rigidity, which, to a greater or lesser extent, generally follows these injuries.

Dr. Allis[1] treats these fractures with the arm in the extended position without a splint, and gives fixation to the fragments by means of strips of binder's board or leather, held in position by a bandage or strips of adhesive plaster, and claims that the resulting deformity and impairment of motion is less under this method of treatment.

Fracture of both radius and ulna, or, as it is generally described, fracture of both bones of the forearm, is treated by making extension from the hand to overcome the deformity; two well-padded splints, a little wider than the forearm, and long enough to extend from the tips of the fingers to the elbow, are then applied to the dorsal and palmar surface of the forearm, and held in place by a roller bandage.

In applying the anterior splint, care should be taken that it does not press against the brachial artery at the bend of the elbow when the arm is flexed, which has been followed by the most disastrous consequences.

Having applied the splints, the arm should be carried in a broad sling suspended from the neck; the forearm should be kept in a position between pronation and supination, that is, with the thumb looking upwards. This position offers the widest separation of the bones; and, in case of redundant callus, or inward displacement of one of the fragments, gives the patient the best chance of retaining perfect motions of pronation and supination. When there is a tendency to lateral displacement of one of the fragments, this can be corrected by the use of a compress.

This dressing is usually retained from four to five weeks. Prof. Ashhurst, in dressing this fracture, applies two splints, an anterior splint extending from the fingers to the bend of the elbow, and a posterior short splint extending from the elbow to the wrist, and prefers that the forearm be carried in the supine position, as advised by Lonsdale; this position he thinks most important when the fracture of the radius is in its upper portion, preventing union with axial deformity where the upper fragment may be supinated by the action of the biceps muscle.

Fracture of the olecranon process of the ulna is treated, first, by the application of the initial bandage from the fingers to the shoulder; and if there be displacement of the fragment by the triceps muscle, it is replaced and held in position by strips of adhesive plaster or by figure-of-eight turns of the bandage about the elbow. The arm is now placed upon a well-padded, anterior angular splint, with the angle so obtuse as to

[1] Proceedings of Phila. County Med. Soc., 1878-'79, p. 79.

hold the arm in a position of moderate extension, this position being found more comfortable for the patient than that of absolute extension. A straight splint with extra padding corresponding to the position of the bend of the elbow fulfils all the indications. Either of the above splints are applied and held in position by a bandage, and are permanently removed at the expiration of five weeks.

Fracture of the radius at its upper portion, or fracture of the ulna alone, are treated with the same dressings that are applied in fractures of both bones of the forearm. Fractures at the lower portion of the radius—those described as Barton's, Colles', or Smith's fractures of the radius—are generally treated upon the Bond splint, which consists of a piece of light wood, carved into somewhat the shape of the forearm, and on the lower portion of this a block is fastened in an oblique direction, over which the fingers rest, and this, from its oblique position, causes abduction of the hand when grasped by the fingers, and corrects the adduction so often seen in these fractures.

The deformity on the palmar and dorsal aspect of the wrist is corrected by extension and by the use of two compresses, one applied over the upper end of the lower fragment, and the other applied over the lower end of the upper fragment. The splint and compresses are then held in position by a roller bandage, and the forearm is carried in a sling, with the hand in a position between pronation and supination.

The splint, in addition to correcting the adduction of the hand, allows moderate motion of the fingers without disturbing the fragments; it is usually retained for four weeks, then laid aside, and motions at the wrist encouraged.

The pistol-shaped splints of Nélaton are also occasionally used.

Dr. Levis,[1] for the treatment of this fracture, has devised a splint of tinned copper, moulded to fit the forearm and hand, which is made either for the right or left hand, and when applied allows the hand to remain in a moderately flexed position, a compress is also used on the dorsal surface of the wrist; he insists upon a perfect reduction of the fragments before the application of the splint, as a most important factor in the production of a good result.

Fracture of the metacarpal bones are treated by the application of a short palmar splint, well padded to fill up the concavity of the palm of the hand, and if there be a projection of the fragments upwards it is remedied by the use of a compress; the compress and splint are then held in position by a roller bandage.

Fractures of the phalanges are treated by the use of a long, straight splint, extending from the tip of the injured finger to the wrist, and by two or three short splints applied to either side of the finger; the long splint may be applied either upon the palmar or dorsal aspect of the finger.

The splints may be held in position by a narrow bandage or by strips of adhesive plaster.

A binder's board splint moulded to the injured finger and held in position by a bandage, strips of adhesive plaster, or by a plaster-of-Paris bandage, is also sometimes employed in the treatment of these injuries.

[1] Surgery in the Pennsylvania Hospital, p. 269.

MEDICAL PROGRESS.

ATROPINE AS A CAUSE OF GLAUCOMA.—Atropine has of late years been so widely used in ophthalmic practice, both in the treatment of various painful affections, and also merely for the purpose of paralyzing the pupil to facilitate the estimation of errors of refraction, or an examination with the ophthalmoscope, that the warning afforded by Mr. Streatfield's letter, in the *British Medical Journal*, and to be found also in a case read to the Ophthalmological Society, by Mr. Snell, and reported in the same journal for July 15, has not been sounded too soon. It thus appears, on the evidence of competent judges, that a strong solution of atropine, such as is the officinal solution of the *British Pharmacopœia*, is capable of producing glaucoma in some cases. A way out of the difficulty is afforded by Mr. Streatfield, who points out that a solution very much weaker than that provided by the *Pharmacopœia* would suffice to produce sufficient mydriasis for all ordinary purposes. Dr. Ringer has, we believe, made some experiments on this subject, and has found that a dilatation of the pupil, lasting some hours, can be produced by a solution containing what a chemist would consider a mere trace of atropine. A solution formed by diluting the pharmacopœial "liquor" with two or three hundred times its bulk of water, would be sufficiently strong.—*British Medical Journal*, July 29, 1882.

SUBCUTANEOUS INJECTION OF IODOFORM IN SYPHILIS.—DR. THOMANN has treated a number of cases of syphilis by subcutaneous injections of iodoform; after ten or twelve injections he has always observed a great improvement of the symptoms. The preparation is composed of six parts of iodoform in twenty of glycerine, and he injects progressively thirty to seventy-five centigrammes. He has never had an abscess to occur; the iodine is to be found in the urine in about two hours; no trace of the odor of iodoform occurs in the breath, in the sweat, or urine. He also made use of a solution of iodoform in olive oil, but found it much more irritating.—*Bull. Gén. de Ther.*, July 15, 1882.

THE TREATMENT OF HÆMORRHOIDS BY INJECTIONS OF CARBOLIC ACID.—DR. CHARLES B. KELSEY, Surgeon to St. Paul's Infirmary for Diseases of the Rectum, New York, recently opened a discussion on the treatment of hæmorrhoids, at a meeting of the New York Clinical Society, by reading a paper on the treatment by injections of carbolic acid. The paper, which appears in the August number of the *New York Medical Journal and Obstetrical Review*, opens with condensed histories of a number of cases, after which he remarks that, beginning this plan of treatment without very much confidence in it, and with the fear of causing great pain, and, perhaps, dangerous sloughing, constantly before him, the method is constantly growing in favor with him, and the more he practises it the more confidence he gains in it. With solutions of proper strength the danger of causing sloughing of the tumors is very slight. There are no objections to this method which do not apply equally to others. He has once seen considerable ulceration result from it in the hands of another; but he has seen an equal amount follow the application of the ligature; and he does not consider this as a danger greatly to be feared when injections of proper strength are introduced in the proper way. It is applicable to all cases; is especially adapted to bad cases; and may be used where a cutting operation is inadmissible. It acts by setting up an amount of irritation within the tumor which results in an increase of connective tissue, a closure of the vascular loops, and a consequent hardening and decrease in the size of the hæmorrhoid. Except when sloughing occurs, the tumors are not, therefore, removed, but are rendered inert, so that they no longer either bleed or come down outside of the body. In cases in which the sphincter has become weakened by distention, the injections will also have a decided effect in contracting the anal orifice, as injections of ergot or strychnia do in cases of prolapsus. He has used this method of

treatment now many times, and has never, except in one case, had reason to regret using it or to be dissatisfied with its results, so far as he has been able to follow them. Although slow to advocate any one treatment of this affection to the exclusion of all others, he now generally adopts this from the outset in each case, reserving Allingham's operation for any in which the injections may fail. As yet he has met with no such case. Its advantages over all other methods, provided its results prove equally satisfactory, are manifest. The patient is not terrified at the outset by the prospect of a surgical operation, is not confined to his bed, and is not subjected to any suffering. The cure goes on painlessly, and almost without his consciousness. The method requires some practice and some skill in manipulation, in getting a good view of the point to be injected, and in making the injection properly; but this is soon acquired; and he is more and more convinced that the fear of producing ulceration is an exaggerated one, and that when ulceration is produced it is a result either of a solution of too great strength, or of one improperly administered.

OVARIOTOMY IN SWITZERLAND.—In a recent number of the *Revue Médicale de la Suisse Romande*, Prof. Socin, of Bâle, makes some observations with regard to the statistics of his cases of ovariotomy, as recorded in a paper on the subject in a recent No. of the *Brit. Med. Journ.*, and in the above-mentioned Swiss journal, April 15, where Prof. Kocher reproduced the substance of the latter article. In both contributions, Prof. Socin's operations were placed under "cases of ovariotomy by surgeons who have operated under carbolic spray in every case," but in the English article, 12 operations, with 4 deaths, were placed against the name of Prof. Socin, whilst Prof. Kocher gives 11 cases, with 4 deaths, in his tables. Prof. Socin now states that there are two errors in the articles on ovariotomy in Switzerland, which he desires to rectify. "The first is through an omission on my own part, for I failed to record two successful cases; this raises my total to 13, out of which 4 were fatal. In the second place, it is not correct to include all my operations amongst those conducted with antiseptic precautions. My first ovariotomy was performed on February 21, 1867, my second on July 20, 1869, when antiseptics were not in vogue. The next two cases come under the same category. Consequently, my first four cases, which include two deaths, one from collapse on the day of the operation, the other from septic peritonitis on the seventh day, cannot be taken into account in the consideration of antiseptic surgery." One death from shock half an hour after operation, and one from suppurative peritonitis which had existed before the operation, occurred among Prof. Socin's antiseptic cases. In the same series was a successful case of removal of a cystic ovary, in a patient who returned to hospital, two years later, with a large uterine fibro-myoma. He also successfully performed "supravaginal hysterotomy and the extirpation of the second ovary, which was healthy." —*British Medical Journal*, July 29, 1882.

CURE OF HYDROPHOBIA.—At the meeting of the Académie de Médecine, held on July 11th, M. DECROIX read a paper entitled *Nine Cases of Cure of Hydrophobia*, of which the following are the conclusions:

1. It has been demonstrated that hydrophobia can be cured spontaneously.

2. It has never been proved that the cures in cases which recovered were due to the influence of drugs, and did not occur spontaneously.

3. All the methods recommended by the Committee of 1874 comprised the injection of nitrate of pilocarpine, and have rather hastened than retarded death.

4. Blunting the teeth of dogs is the best preventive of the propagation of the disease.

5. Persons and dogs suffering from hydrophobia should be left in perfect repose.—*Gaz. Méd. de Paris*, July 15, 1882.

INTRODUCTION OF ALIMENTS AND MEDICINES THROUGH THE NOSE.—FERNET and MARTEL (*Schmidt's Jahrb.*, 1882, 1.) have made a number of experiments to demonstrate the possibility of introducing ailments and medicines through the nostrils.

For this purpose the patient is placed on his back, in the recumbent position, while the head and the upper part of the throat are permitted to fall somewhat backward. The gum hose of a common nursing bottle is then pushed into the posterior part of one nostril, and the fluid—either containing nutritive substances or medicine—slowly poured in. In consequence of the peculiar position of the body, the floor of the nasal cavity and the velum form an oblique plane, so that the fluid mentioned flows directly into the pharynx and induces swallowing. Generally, and especially if the fluid is poured in slowly, the expected result ensues with certainity, and in a manner by no means disagreeable to the patient; only when the fluid is poured in too rapidly, a few drops may find their way into the larynx, causing the well-known irritating cough.

Fernet and Martel have employed this method successfully in persons in a comatose condition, in children suffering from tubercular meningitis, and even in newborn infants too weak to take the breast or the bottle. This method may also be successful in introducing such medicines into the stomach which, in consequence of their bitter or nauseous taste, are rejected by the patient.

Créquy recommends, for this purpose, the introduction of a flexible gum tube (catheter). If this is pushed behind the velum, the possible reflow of the fluid, by the other nostril would effectually be prevented.

Martel reports two cases: one, where, in consequence of a fall on the head, severe concussion of the brain, with trismus and utter inability to swallow, set in, and the other, a case of pneumonia in a drunkard, the patient being totally unconscious. Here the medicines—calomel and jalap in the first, musk and digitalis, in the second, case—were successfully carried into the system by the method described, and though in consequence of their severity the cases ended fatally, the procedure itself achieved its object.—*Medical and Surgical Reporter*, August 5, 1882.

TUBERCULAR OSTEO-ARTHRITIS.—At the meeting of the Société de Chirurgie, held June 28th, M. LANNELONGUE drew the following practical conclusions from a study of this subject:

Tubercular osteo-arthritis may occur in two different forms depending upon its phase of development. In the latent stage, when the synovial membrane is scarcely affected, any intervention is uncalled for, immobilization and extension with good hygiene being sufficient. When synovitis occurs, ignipuncture or interstitial injection will give the best results. Should an abscess occur, it should be opened, and the diseased bone sought for and removed.—*Bull. Gén. de Ther.*, July 15, 1882.

USE OF IODOFORM IN THE BUCCAL CAVITY.—The effects of iodoform in tubercular joint affections, as well as the certain and reactionless course which non-sutured wounds of the surface or of cavities run under the application of this drug, suggested the advisability of testing its value in wounds of the natural openings of the human body; and the more so on account of the difficulty which has hitherto been experienced in carry-

ing out antiseptic treatment in those regions. Numerous operations in the buccal cavity, lately performed in Prof. Billroth's clinic, have afforded us a certain amount of experience in this direction. From April to October, 1881, eighteen lingual carcinomata were extirpated. In some of the cases a third or a half of the organ, but in the majority the whole tongue, was amputated. Simultaneously more or less of the floor of the mouth had to be removed, the excavation sometimes extending to the hyoid bone and digastric tendon, and including the submaxillary and adjacent cancerous lymphatic glands. Besides, in several instances the inferior maxilla was partially resected, or portions of the soft palate and pharynx were excised. Ligatures were, as a rule, applied beforehand to the lingual and external maxillary arteries. In all these eighteen cases a cure was the result. There was no reaction in any of the wounds, and in most of the cases there was no rise of temperature observable after the operation. There was an absence of those complications which were formerly observed after extirpation of the tongue. There can scarcely be a doubt that these favorable results stand in direct relation with the employment of iodoform, for the *technique* of the operation has undergone no alteration. The points to be kept in mind in this method of wound-treatment, as reported by WOLFLER, *Centralb. f. Chir.*, are the following: When, after extirpation of the tongue and floor of the mouth, the wound made in ligaturing the arteries before mentioned communicates with that in the buccal cavity, the latter is drained by means of a tube of the thickness of a finger. If no such intercommunication exists, it is not purposely set up. In all cases the edges of the ligature-incision are brought together with sutures. After the operation, and in size corresponding to the depth and width of the wound, a strip (four-ply) of iodoform gauze, six to eight inches long and one and a half to two inches wide, is introduced into the mouth, and pressed with moderate firmness against the sides of the cavity, which it quite fills up. This small quantity of gauze suffices to keep the wound completely and lastingly aseptic. The first dressing usually remains adherent to the surfaces of the wound for from five to eight days. It does not separate of itself during these first days, and even then need not be changed if the patient is taking fluid nourishment. It must be especially noticed, however, that ordinary gauze does not adhere so certainly as that prepared in the following manner: 60 grammes of colophony are dissolved in 1200 grammes of alcohol, and 50 grammes of glycerine are added to the mixture. In this six metres of purified gauze are soaked, then wrung out, and dusted with 50 grammes of pulverized iodoform. If we compare these recent results with our former experiences after extirpation of the tongue, we must feel convinced that in iodoform we have found an agent for treating wounds of the buccal cavity, the mode of application of which is as simple as its antiseptic qualities are trustworthy.—*Edinburgh Medical Journal*, July, 1882.

AMYLOID KIDNEY WITHOUT ALBUMINURIA.—J. STRAUSS (*L'Union Médicale*) concludes a paper on amyloid kidney without albuminuria as follows:

1. In certain cases of amyloid degeneration of the kidneys, albuminuria may be constantly absent until death.

2. The absence of albuminuria is due on the one hand to the absence of a deep lesion (interstitial or epithelial) of the kidney, and on the other hand to a special localization of the amyloid degeneration. This, in such cases, bears chiefly upon the *vasa recta* of the medullary substance and implicates in a minor degree the glomerular vessels.

3. From a clinical point of view, if in a phthisic, or an inveterate syphilitic, or a subject of chronic osseous suppuration, etc., we find enlargement of the spleen and of the liver, but *without albuminuria*, we are not justified on this account in rejecting the idea of amyloid degeneration of the viscera, nor even in absolutely denying amyloid degeneration of the kidneys.

4. Those authors who date the beginning of amyloid degeneration in the economy from the moment at which they observe the presence of albumen in the urine, commit a double error, (*a*) because amyloid degeneration is far from beginning always by invading the kidneys. On the contrary, the spleen and the liver are habitually the first to be attacked, (*b*) because the kidney itself may be suffering from amyloid degeneration without albuminuria being present. It is then necessary to mistrust calculations by which it has been sought to fix the possible duration of life in subjects afflicted with amyloid cachexy, by making this date from the first appearance of albuminuria.—*Canadian Journal of Medical Science*, August, 1882.

FISSURE OF THE NECK OF THE BLADDER.—M. REGINALD HARRISON thinks that fissures commencing in the prostatic urethra, and involving the vesical orifice, are frequently causes of irritable bladder. The symptoms of fissure of the vesical orifice are analogous to those observed elsewhere. There is pain on micturition, and a sensation of contraction and dilatation at the close of the act, accompanied with a sharp stinging pain behind the scrotum which is very significant. Occasionally a few drops of blood escape as micturition terminates. The pain varies in degree in the same patient, being intense when the urine is highly acid and less so when it is neutral or alkaline. Examination of the prostate by the rectum invariably produces on pressure a sharp sensation as if a knife were piercing the gland. Similarly, the passing of a sound in the bladder is distressing. Occasionally these cases are referred to some gouty or rheumatic disorder; by the French the term *contracture du col vésical* often includes them. When this affection is considered to be traceable to either gout or rheumatism, the patient is almost invariably placed on an alkaline treatment with decided advantage, for the reason already mentioned. The improvement is, however, only temporary, and is directly traceable to the altered reaction of the urine. Vesical fissure is, however, seldom cured, though it may be palliated by such means; in addition rest and the application of a weak solution of nitrate of silver directly to the prostatic urethra are sometimes effectual.

On more than one occasion Mr. Harrison has succeeded in effecting permanent benefit by temporarily paralyzing the sphincter action of the neck of the bladder. The relief that immediately follows cystotomy in vesical fissure, otherwise irremediable, justifies the risk of a proceeding which is considerably less than that attending many other operations more frequently and less hesitatingly performed.—*Liverpool Med. Chir. Journ.*, July, 1882.

DOUBLE UTERUS AND VAGINA.—DR. HEYWOOD SMITH exhibited on July 27, in the theatre of the Hospital for Women, a case of rare occurrence with complete double uterus and vagina. The right vagina was rather the larger, the orifice of the left being rather hidden in the folds that the edge of the septum formed. Both vaginæ were perfect; the cervices were distinct, with small ora. Both were shown simultaneously by two specula. The sound passed upwards and rather outwards on the right side, two and a half inches, and on the left similarly to two and a quarter inches. *Per rectum*, it was found that the double uterus was united and flattened as far as the body, and the two fundi were separate and diverged, so that the whole organ

presented somewhat the shape of a Y. Menstruation was regular, somewhat scanty, with pain in both inguinal regions. Dr. Heywood Smith had seen a similar case in a young girl some years previously. Dr. Rogers, who was present, said he had seen five cases. It would be interesting if observers would report all cases of complete double uterus and vagina. This patient has been married eight years, but has never been pregnant.—*British Medical Journal*, July 29, 1882.

TREATMENT OF GENU VALGUM.—M. ROBIN (*Lyon Méd.*) has devised a new osteoclast for the radical cure of genu valgum. It consists of an iron case extending half way around the thigh on its anterior aspect, from a point a short distance above the condyles of the femur upward to the superior third of the thigh; two steel collars bind this to a piece of heavy plank, one at its lower, the other at its upper, limit: each collar is fastened to the plank by a nut and screw. This portion of the apparatus holds the femur secure. To the upper or superior portion of the lower collar an upright is securely fastened, having a slot at its upper end, at right angles to the collar and parallel to the long axis of the limb. Into this slot is fitted the end of a long lever, which extends down over the leg. A strong leather collar, large enough to surround the femur at the condyles and pass over the lever above, completes the apparatus. It will be evident that the lever will act, when pulled upward, as one of the second order, where the weight is between the fulcrum and the power. The object aimed at in the use of this osteoclast is to cause a transverse fracture, either complete or incomplete, just above the epiphyseal line of the femur in the direction from behind forward, or rather from within outward and upward. The following is the method of using it: The patient being etherized, the thigh is placed on the wooden frame, the iron splint or case is placed over the thigh and securely fastened to it by the steel collars; the leather band is placed around the lower end of the thigh, so as to grasp the condyles, and then over the lever. Just before applying the power the limb is rotated outward, and the force is applied by forcing the lever upward. The vessels and nerves, being protected by the condyles, escape any pressure. It is found that the femur is fractured just above the condyles, and that correction of the deformity can be readily made.—*New York Medical Journal*, August, 1882.

THE RADICAL CURE OF VARICOCELE.—M. REGINALD HARRISON describes his method of operation as follows: It consists in exposing the cord by a vertical incision about an inch in length and separting the veins which are most prominently varicose. These are each tied in two places with a catgut ligature. Usually three or four main veins require to be so dealt with. In addition, it will be observed that there are a number of small veins in plexuses or bundles, especially in close proximity with the epididymis, which cannot be obliterated in this way; these he destroys with a few light touches of the thermo-cautery, taking care, while this is being done, to protect the vas deferens by holding it from behind, between the thumb and index finger of the left hand. The operation is conducted antiseptically. No sutures are introduced, and the wound is left to heal by granulation. He has now been performing this operation for some years, and he is not aware of an instance in which there has been a return of the varicose condition of the veins; the cicatrix which results is of a contractile nature, such as usually follows wounds inflicted by burning, and gives a feeling of firmness to parts which previously were complained of as being unnaturally lax. It is a matter of great importance, in view of preventing a return of the disease, to destroy the small varicose veins, which can only be seen and not felt. If this is not done, obliteration only means driving the disease into new channels, already preparing to dilate.

He has operated on the spermatic veins in this way a great many times. In one instance only was any delay or danger imported into the case. This was an attack of erysipelas, which was directly traceable to the patient sitting on a draughty watercloset very shortly after the operation was performed. Though here there was delay and some danger, the result was satisfactory. As to the necessity for performing an operation with a view of effecting a radical cure, the sensations of patients, in addition to changes taking place in the testicle, are sufficient to indicate this. Hence, in deciding what is to be done, it is of importance to have under notice the various procedures having for their object the same result.—*Lancet*, March 25, 1882.

HYPODERMIC INJECTIONS OF PILOCARPINE IN SCARLATINOUS URÆMIA.—PROF. SEMMOLA has made a very important observation by which he clearly establishes the influence of pilocarpine in scarlatinous uræmia. The details of this case, which emphasize the relations too often forgotten between the skin and kidneys, will be read with interest.—*Bull. Gén. de Ther.*, July 15, 1882.

A CASE OF TRIPLETS.—Triplets occur in France but once in 8256 labors. The case reported by HERGOTT (*Ann. de Gynécol.*, June, 1882) is the only one that has occurred in the last ten years in the maternity at Nancy. It is as follows: S., aged twenty-four, nullipara, entered hospital in labor five hours. Membranes had ruptured, cervix was obliterated, os dilated one inch, auscultation reveals two fœtal hearts, one above umbilicus and to the right, the other below; on the left nothing is heard. Palpation is difficult, but one head is determined above on the right, a second is engaged. In two hours a female is born, followed shortly by a male. A third fœtus is then discovered, presenting by the breech. Is soon born, and is a male. One female and two males is usual, but, usually, the presentation for all is vertex. The placenta was double, united by a membranous band. Each fœtus had separate cords, but those of the males united and were inserted into the same placenta. Each fœtus was inclosed in separate membranes. On the third day the last child born died; the following day the second male; fifteen days after, the female. The mother recovered.—*Amer. Journ. of Obstetrics*, August, 1882.

HEART TUBERCLE.—HIRSCHSPRUNG (*Jahrb. für Kinderh.*, xviii., 2 and 3) reports an interesting case of a girl eight years old, who was a healthy looking child, but on admission to the hospital had serious symptoms pointing to the cardiac region, and represented by a tumultuous action of the heart, diffuse pulsation, increased cardiac dulness, slight cough, heightened temperature, and increased respiration. Dyspnœa and cyanosis set in, and the child died seven days after entering the hospital. A tubercle as large as a walnut was found in the internal wall of the left ventricle; a few miliary tubercles in the anterior part of the left upper lobe, and nowhere else in the lung; the bronchial glands, especially on the left side, were found in a state of cheesy degeneration, as were also the mesenteric glands; there were tubercles in the spleen and pericardium. The liver and spleen were enlarged, and the intestinal glands swollen but not ulcerated,—*Boston Medical and Surgical Journal*, August 3, 1882.

RESECTION OF THE PYLORUS.—MR. SOUTHAM says that, if called upon to perform this operation again, he should be disposed to introduce one or more drainage-

tubes into the abdominal cavity through the external wound, or through a counter-opening made in the loin, and attempt to draw off from time to time, by means of a syringe, any inflammatory effusion which might collect there, according to the plan sometimes adopted in cases of ovariotomy. As regards the operation itself, which has not hitherto been adopted in this country, it has now been performed on fifteen occasions by Billroth, Wölfler, and others with considerable success, five recoveries having taken place, and one patient was recently described as being alive and in good health—the digestive functions being in no way impaired—eight months after its performance.

It is, he thinks, therefore well worthy of further trial; but in order that it may be successful, it should only be performed in the early stage of the disease, when the pylorus alone is involved, and where the general condition of the patient is such, that he will be able to bear the severe shock which is necessarily attendant upon so serious an operation.—*Brit. Med. Journ.*, July 29, 1882.

EMPLOYMENT OF OXYGENATED WATER AS AN ANTISEPTIC IN SURGERY.—MM. PÉAN AND BALDY have made use of oxygenated water as an antiseptic application to wounds, and think that their results will compare favorably with cases in which alcohol, either simple or camphorated, or carbolic acid, has been used. Oxygenated water has the further advantage of possessing no odor and no toxic properties.—*Gaz. Hebdomadaire*, July 14, 1882.

THE TREATMENT OF FRESH WOUNDS.—DR. JOHN DUNCAN draws the following deductions from his observations:

1. That when we succeed in preventing sepsis at the operation we can by this method rely on singularly simple and favorable progress, with total absence of fever, with freedom from pain, and with great rapidity of healing. It is proper to be exceedingly careful in the arrestment of hemorrhage; but even did a little reactionary oozing occur, it is only necessary to renew the dressing once, or, as he did in some of these cases, to put on an additional layer of wool.

2. That should sepsis lead to inflammatory action, it is necessary temporarily to abandon the dressing.

3. That even in septic cases it is often advantageous to continue it throughout if there be no inflammation, or recur to it when inflammation has subsided, because it is a good excipient for discharge, because it tends to diminish the amount of pus, and because it aids in keeping the part at rest.

4. That in fresh wounds so situated that they can be firmly and equably compressed the introduction of materials to secure drainage is usually unnecessary, and that if the drainage-tubes be introduced they should be removed in twenty-four hours.

5. That sepsis is less apt to occur by this method, as it avoids the risks which attend changes of dressing and movements of drainage-tubes, which, in my experience, are more fruitfnl sources of failure than even the original operation.—*Edinburgh Medical Journal*, July, 1882.

DYSMENORRHŒA RELIEVED BY REMOVAL OF A HYPERÆSTHETIC HYMEN.—At a recent meeting of the New York Obstetrical Society DR. ROBERT WATTS reported the case of a patient, nineteen years of age, who said she commenced to menstruate at the age of twelve. The periods were regular, but were accompanied by a great deal of pain—a feeling of fulness and bearing down in the pelvis, and pain in the back. There was also headache, described by her as sick headache. There was disturbance of the stomach These symptoms lasted several days; the flow continued from seven to nine days. It was slow, and sometimes was in the form of clots. This condition had existed ever since she commenced to menstruate. About two years ago she consulted a physician in Chicago, who made an examination, and told her that she was malformed, and was "not a natural woman." This distressed her very much, and she continued to suffer in the same way until Dr. Watts saw her. On attempting to make a vaginal examination, he found the parts exquisitely sensitive, and was unable to introduce the finger. This he supposed was due to the existence of vaginismus, but more careful inspection revealed a very close hymen, which was somewhat elastic, and could be pushed up before the finger a certain distance, although it caused exquisite pain. In its centre was an opening large enough to admit an ordinary uterine probe. Owing to the condition of the parts, no examination could be made until after the hymen had been cut. Nothing abnormal could be discovered about the uterus. Ten days later she menstruated without any pain, without any headache, or any of the uncomfortable symptoms of which she had previously complained, and she had since remained perfectly well. She had been taking singing lessons, but her voice had become so weak that her teacher had rather advised her to discontinue them; since the operation, however, he had spoken to her of the great improvement which had taken place in her voice. Whether this change in the voice was due to the general improvement of the health, or to the removal of this source of irritation, Dr. Watts was unable to say. He had never seen a similar case.—*New York Medical Journal*, August, 1882.

LIGATURE OF THE EXTERNAL CAROTID.—At the recent meeting of the Société de Chirurgie, on June 27, in reference to the point of election in ligation of the external carotid, M. FARABOEUF said that the principal objection urged to the situation between the origins of the superior thyroid and lingual arteries was the difficulty in finding the vessel. M. Faraboeuf, however, showed that the artery lies directly under the greater horn of the thyroid bone, and by cutting down on this point the point of election was readily found.—*Gaz. Méd. de Paris*, July 15, 1882.

INTRA-UTERINE VACCINATION.—DR. BEHM has made a number of experiments as to whether vaccination of the mother in the last few weeks of pregnancy renders the child after birth insusceptible to the vaccine virus, and his results show that while, like variola, vaccinia may be transferred from the mother to the unborn child, this result occurs very seldom.—*Berliner klin. Woch.*, July 17, 1882.

ANTISEPTIC TREATMENT OF PULMONARY CONSUMPTION.—DR. J. BURNEY GEO describes a simple and convenient form of respirator for the treatment of consumption by antiseptic inhalation, and mentions a number of drugs with which he has had experience.

Of all these, he prefers creasote; but he also frequently uses carbolic acid and eucalyptol, with which he sometimes mixes a little camphor. Turpentine is a useful addition as an astringent, where there is profuse secretion or a tendency to hemorrhage. Camphor has been said to be a very powerful antiseptic, but it has the objection of diffusing itself very rapidly, and is unpleasantly pungent and penetrating. He has also found it a very convenient plan to mix these substances, such as creasote, carbolic acid, eucalyptol, or turpentine, with equal parts of spirits of chloroform. It helps to diffuse and vaporize these substances, and it is itself somewhat of an antiseptic; and it has also a soothing

effect on the often irritable bronchial mucous membrane. He has often seen a patient tormented with cough at night, so much so as to be unable to get any sound sleep, obtain perfect relief from this distressing symptom by using at bedtime one of these inhalations in an instrument of this kind. The quantity required for this purpose is often quite inconsiderable; it is rarely necessary to use more than twenty minims of a mixture of equal parts of creasote and spirits of chloroform dropped on the sponge at a time, and renewed occasionally as it becomes exhausted; and it is often desirable to begin with very small quantities, until the patient gets used to the vapor. Five drops of the mixture may be dropped on the sponge at a time, and gradually increased to fifteen or twenty. One of the advantages of the little inhaler he describes is that, being perforated all over, the access of air is unimpeded, while the vapor diffuses itself freely into the immediately surrounding atmosphere. With more solid inhalers, patients will often say they feel "stifled," and refuse to use them.

The substances named are, he believes, the best for continuous, or almost continuous, inhalation; for occasional inhalation, a weak iodized vapor will often be found very useful, and even a very dilute chlorine vapor is well borne by some patients.

Iodine vapor may be diffused through a room or small chamber by throwing fragments of iodine on a heated plate, as he now does; or it may be inhaled from the surface of hot water, by pouring a few drops of tincture of iodine on the top of hot water contained in a suitable vessel, and holding the mouth and nose over the vapor, with some light covering over the mouth and nose and vessel. The vapor of tar may be inhaled in the same manner. A sleeping apartment may be impregnated with tar vapor by putting some tar on a heated metal plate, or stirring a vessel containing tar with a piece of heated metal of any kind. Other antiseptic substances which are not volatile or are vaporized with difficulty may be inhaled in solution in the form of spray. A Siegle's spray-producer is the instrument usually employed for this purpose.—*British Medical Journal*, July 11, 1882.

SALICYLATE OF SODA.—PINSKER (*Archiv f. Kinder.*, ii., No. 12) concludes from a large number of observations on the use of this drug in children, that its ill effects, such as loss of appetite, nausea, vomiting, ringing in the ears, giddiness, deafness, at times appearances of collapse, albuminuria, erythema, and urticaria, are oftenest seen when the drug is impure. While finding it almost a specific in acute rheumatism, it exerted very little effect on diphtheria, pertussis, and typhoid, and was useless in intermittent fever.—*Boston Medical and Surgical Journal*, August 3, 1882.

EXAMINATION OF SPERMATIC STAINS. — VOGEL (*Wiener Med. Blätt.*, 1882) recommends the following method: The stain is softened with water, and in the moist condition is taken off with a knife, avoiding as much as possible the removal of any of the tissue on which it lies. A few small hairs are unimportant, however, as they are readily dissolved from the scrapings on the object-glass or slide with a drop of concentrated sulphuric acid. After two minutes one or two drops of tincture of iodine are added, the whole stirred carefully with a glass rod, and covered with a large cover-glass, which, if the dark-brown mass be too opaque, may be pressed down a little, unless it be intended to transfer smaller portions to other slides. The spermatozoa are stained distinctly brown, and are visible under the microscope in their whole contour, but it is not possible to keep the staining in longer than twenty-four hours unless the sulphuric acid be washed out, when the preparation is soon spoiled. Alcohol at once decolorizes the spermatozoa, showing the staining to be only superficial. — *Boston Medical and Surgical Journal*, August 10, 1882.

THE POISONOUS CONSTITUENTS OF TOBACCO-SMOKE. —A series of experiments has been recently conducted by Herr Kissling, of Bremen, with the view of ascertaining the proportions of nicotine and other poisonous substances in the smoke of cigars. His paper, in *Dinglers' Polytechnisches Journal*, gives a useful *résumé* of the work of previous observers. He specifies, as strongly poisonous constituents, carbonic oxide, sulphuretted hydrogen, prussic acid, picoline-bases, and nicotine. The first three occur, however, in such small proportion, and their volatility is so great, that their share in the action of tobacco-smoke on the system may be neglected. The picoline-bases, too, are present in comparatively small quantity; so that the poisonous character of the smoke may be almost exclusively attributed to the large proportion of nicotine present. Only a small part of the nicotine in a cigar is destroyed by the process of smoking, and a relatively large portion passes off with the smoke. The proportion of nicotine in the smoke depends, of course, essentially on the kind of tobacco; but the relative amount of nicotine which passes from a cigar into smoke depends chiefly on how far the cigar has been smoked, as the nicotine contents of the unsmoked part of a cigar is in inverse ratio to the size of this part—*i. e.*, more nicotine the shorter the part. Evidently, in a burning cigar, the slowly-advancing zone of glow drives before it the distillable matters, so that in the yet unburnt portion a constant accumulation of these takes place. It would appear that in the case of cigars that are poor in nicotine, more of this substance relatively passes into smoke than in the case of cigars with much nicotine; also that nicotine, notwithstanding its high boiling point, has remarkable volatility.—*Scientific American*, August 12, 1882.

THE ANTIPYRETIC ACTION OF ALCOHOL.—The conclusions drawn by DR. GREBE, from his experiments upon the antipyretic action of alcohol (*Arch. f. wiss. u. pract. Thierh.*) are as follows:

1st. The action of alcohol upon the temperature varies, according as it is given in small or large doses.

2d. In small and moderate doses alcohol, when given to animals with fever, produces an immediate slight increase in the bodily temperature, amounting to about 1° F.

3d. This increase is of short duration, and is followed by a fall of temperature to a lower level than before the alcohol was taken.

4th. In large, but not poisonous doses, alcohol depresses the temperature without any previous rise. The fall may amount to several degrees.

5th. A long-continued fall of temperature can only be obtained by giving large doses at regular intervals. Given in this manner, alcohol is a true antipyretic.

6th. Alcohol has its antipyretic effect by virtue of its power to hinder or lessen oxidation. The author states that in fever the red blood-corpuscles are diminished in number, but that by giving alcohol in antipyretic doses they reach their normal amount again. This assertion, first made by Manassein, was confirmed by Grebe.

The various theories offered to explain the heat-depressing powers of alcohol are discussed by our author. He is inclined to give the most weight to the power which alcohol has of delaying tissue-changes. Grebe's conclusions are in harmony with those of most of the other very numerous investigators in this line.—*Medical Record*, August 5, 1882.

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EXTIRPATION OF THE LARYNX.

NINE years ago, when Billroth, one of the most daring and brilliant of modern surgeons, announced the first extirpation of the entire larynx, we all opened our eyes and asked ourselves what next? A query he answered later by an exsection of the pylorus. The latter operation is too recent to invite determinate and especially statistical criticism. But the former operation has now been done so often that we may properly pass its cases in review, and ask ourselves what cases are suitable for it, what is the best method of doing it, and finally whether the results justify the operation.

Dr. Blum, in the *Archives Générales*, for July, 1882, has collected in a convenient brief *résumé* all the cases reported up to date, thus completing Foulis' table presented to the International Medical Congress last year. They number thirty-eight. Among them we find but one case operated on in America, and only six in England. Over twenty have been done by German surgeons, Billroth and Thiersch having each done four operations, and Czerny three. To the latter surgeon also is due the credit of the first tentative steps in the direction of the operation, for in 1870 he demonstrated its possibility on the lower animals, and even designed a canula to replace the larynx and allow of voice. Gussenbauer, however, has produced so far the best artificial larynx—a double canula, the inner one turning upwards and bearing a vibrating reed. Bruns and Czerny have modified it to advantage.

Watson, of Edinburgh, seems really to have extirpated the larynx in man in 1866, but the details of the procedure are not very explicit, and did not establish the operation as did Billroth's case seven years later.

The cases so far have been twenty of carcinoma, ten of epithelioma, six of sarcoma, one of perichondritis, and in one case the nature of the disease is not stated. Practically, therefore, the operation has been, and doubtless always will be, chiefly limited to cases of cancer and its allies; and by no means every case of these fatal diseases will be suitable for operation. So long as the disease is strictly limited to the larynx it may be amenable to operation; but once that it has invaded surrounding tissues, infiltrating them to such an extent that its limitations are uncertain, and its involvement of vessels, nerves, and other important tissues is extensive, the operation clearly would pass out of the realm of the justifiable.

Czerny has just reported in full his three cases in the *Berliner klinische Wochenschrift*. In one of them he operated five times for recurrence of the disease in less than six months, removing not only the diseased structures, but ligating and excising both jugular veins, one carotid artery and one pneumogastric nerve, and Landerer in another case had to excise one phrenic nerve.

The method is now fairly well defined, although it is still possible that improvements will be proposed in its various steps. From the very nature of the diseases requiring it, previous tracheotomy is an almost invariable antecedent condition. Any disease so serious as to demand extirpation of the larynx will almost certainly have produced such a dyspnœa as already to have required tracheotomy. Such was the fact in all these thirty-eight cases, with two exceptions. It is also a favorable condition, since the patient is then accustomed to the use of the canula, and the adhesions of the trachea prevent its ready displacement after the removal of the larynx.

During the operation, and for some eight or ten days after it, a tracheal obturator is required in order to allow the use of an anæsthetic, to keep the blood from choking the patient, and to prevent the detritus and pus from passing into the bronchi. That of Trendelenburg is the best and simplest. It is an ordinary canula surrounded by a short cylinder of rubber tied above and below. When inflated, this cylinder distends and completely fills the trachea, yet great care is required in its use, since its pressure often produces local ulceration and gangrene. After reaching the cartilage we may proceed in two ways, either with Foulis, separating the trachea and the larynx horizontally, and dissecting from below upwards; or with Pick, and most other surgeons, we may divide the thyroid vertically and remove each half separately—the simpler and safer operation. The arteries usually requiring ligature

are the crico-thyroid, the superior thyroid, and the superior and inferior laryngeal. The hemorrhage is not generally alarming, for none of the arteries are very large, and most of them may be tied before being cut, yet Czerny required twenty-seven ligatures in one of his cases. Of course, primary union is not sought for. An œsophageal tube or a large Nélaton catheter is introduced by the wound into the stomach, and left there till granulation is well established, when it may be removed and swallowing by the mouth may be tried. It is surprising in how short a time the unfortunate sufferers can use the œsophagus for this purpose. The artificial larynx may be inserted about the same time—Maurer says not earlier than the fourteenth day. In order that the epiglottis may not interfere with any such artificial larynx, experience shows that its removal during the operation is advisable, and that the tongue generally replaces it as a fender to the trachea; yet it has several times been left with good results, and Landerer advises its preservation.

What now are the results? Out of the thirty-eight cases, eighteen died within a week, and at a later period twelve more, either from the operation or an early return of the disease; only eight were alive at the time of the report, four cases of epithelioma, and two each of carcinoma and sarcoma. But in one of these cases the disease had already returned, and all the others were reported at so brief an interval after the operation as to make the ultimate results very equivocal. Bottini's case had lived without recurrence six years, Caselli's for nearly two years; none of the others for more than a year, and generally much less.

In view of these facts we may well question whether American surgeons have not done well in refusing thus far to do the operation, and in deterring others from doing it, as the sole American case certainly has. If but two or three out of thirty-eight survive for two or three years, and all the rest die, and, as a rule, much more speedily than they would if let alone, is there on the whole a gain of life or even of comfort? Are not the suffering after the operation, the mutilation, the loss of voice, the annoyance of the artificial larynx, of the œsophageal tube, and later of the troubles in swallowing, with the risk to life, and the almost absolute certainty of return with its dreadful discomforts, all taken together, well nigh prohibitory?

Cases of sarcoma seem to be best adapted to the operation, for only (mark the word) two-thirds of these cases have died. But who, as Semon says, "will take upon himself to diagnosticate early and positively carcinoma?" Or sarcoma? The forceps may remove pieces of the growth, but the microscopist cannot tell its character from so small a fragment, and the clinical history in the extreme slowness of the onset, not uncommonly extending over two to five years, the difficulty of deciding the question of the glandular involvement, and the frequent doubt as to possible syphilis, furnish too unreliable grounds for deciding so momentous a question. Some, indeed, so soon as a carcinoma is probable, or even in syphilitic stenosis, would operate out of hand—a rashness we are glad to think that is rarely found.

Dr. Cohen has justly pointed out the miserable condition of those who do not die at once, and that "survival" and "recovery" are by no means identical terms.

Czerny asks, "What would you wish to be done to yourself?" To which we reply, that if our editorial larynx were so diseased, at the proper time we would gladly undergo tracheotomy, and then live in as great comfort as we could attain, and die without the knife.

PROVISIONS AGAINST WATER CONTAMINATION.

A SOCIAL and civic problem of continually increasing importance is the preservation of the water-supply of cities and towns from contamination. It is more especially the duty of the medical profession, through their recognized organs, to expose the dangers of pollution of the potable waters, and to indicate the remedies to be adopted. It is their duty to educate the people, that the necessary legislation may be obtained, and further and more serious mischief prevented. In this country the people must necessarily be in advance of their legislators; they must have a clear conception of their needs, and then the legal remedies can be provided accordingly.

The difficulties in the way of suitable legislation to preserve the potable waters of the country from contamination, are, indeed, very great. The people are not sufficiently well informed to appreciate the nature and the sources of the danger to which their health is exposed by neglect of appropriate sanitary provisions. The sparseness of the population, and the apparent remoteness of the dangers, have influenced the well informed to regard any present precautions as superfluous. The public conscience has been lulled into a state of indifference and fancied security by the confident assertions of the chemists, that potable running waters purify themselves in the course of two or three miles. These various influences have combined against efforts to move the people to act in their own defence. This passive resistance to the proper measures, is even more difficult to overcome than active hostility.

Legislation to prevent contamination of streams and rivers supplying potable waters to cities and towns will always be opposed by certain vested

rights, by the interests of powerful corporations, and by that large body of tax-payers, who never assent to the expenditure of public money for objects which seem to them more largely æsthetical than useful. This opposition can be overcome only by the clearest evidence of pollution, and of the tremendous evils arising therefrom. Within the past few years the water-supply of Boston, Philadelphia, and New York, have alike presented obvious evidences of contamination. When the eye and the taste of the public are assailed, there is no need to appeal to the microscope and chemical tests. General apprehension as to the state of the water-supply in most of the great cities is now felt. The universal inquiry is, how far can our senses be trusted in this matter? The public mind is therefore awake, active, and in a condition of receptivity. What reply do our experts in water analysis make to the anxious inquiry? On their reply, and on the representations of the medical profession, largely depends the fate of the legislation now imperatively demanded. It needs only a reference to the remarkable differences in the results of the London analysts in regard to the condition of the water-supply of that city, to learn that the present state of chemical knowledge does not justify the confidence now expressed by chemists in their ability to define all the products of the reactions occurring in polluted water. For many kinds of impurities, the senses of sight, taste, and smell, afford more valuable information than the processes of the chemist. The mode in which organic matter is now detected is far from satisfactory. It is true, the presence of nitrates, and of ammonia, may be unerringly detected, but these are products of nature's chemical reactions; the substances out of which they are elaborated are not ascertained with a degree of certainty which does not admit of doubts—of serious doubts. It is questionable whether ordinary sewage is disposed of by oxidation, precipitation, and combinations, as is alleged, in the space of two or three miles, ordinary flow. It is certain that disease germs cannot be so disposed of, and these, without doubt, elude the highest chemical skill devoted to their discovery. Many noxious matters from dye and chemical works, minerals from mines, and other similar substances cannot be rendered innocuous by any length of stay in running water. It is obvious, that although we may obtain valuable information from chemical investigations, we ought not to rely upon them in the present state of knowledge, when it is known that various harmful substances, sewage, and disease germs, enter the water-courses. When the drainage of cities, towns, manufactories, breweries, mines, etc., flow into a river furnishing the water-supply, it may be confidently asserted that such water is contaminated to a less or greater extent, although chemical analysis may give negative results.

What then is the remedy? The English, with the practical good sense which distinguishes all their sanitary work, have early recognized the danger arising from pollution of the water-supply, and Parliament has enacted stringent measures to prevent it. Notwithstanding the comprehensive nature of these laws, they have not yet fully succeeded, and there are still loud complaints of sewage contamination, and of poisons from chemical works. But the evils of polluted water are so obvious, that Parliament will not fail to legislate effectively, if the measures now in force prove inadequate.

The legislation demanded in the interest of a pure water, is with us, State and National. Cities should be empowered by the Legislature of each State to provide against contamination of their own supply, and the National authority must be exerted when the necessary legislation includes inter-State regulations. In the absence of suitable laws to prevent contamination of potable waters, what must be the condition of the water-supply to many American cities in the course of the next half century? As populations, manufactories, and various industries increase, the streams will receive all the waste products in increasing quantity yearly, for the selfishness of men can be depended on to secure the easiest and least expensive outlet to their various excretions.

"DIRT WANTED HERE."

SUCH would be an appropriate motto for some of the daily newspapers. News of such a character as to be fit only for the *Police Gazette;* scandals so revolting as only to be whispered from man to man; scenes that bring blushes to the cheek, are all spread abroad in their columns for the community at large to read—men, women, children—and the unsavory mess is made to attract the more attention by large headings in displayed type. Where any crime is involved, any law broken or evaded, any evil liable to befall society, then we can understand and approve the motive which impels the exposure of even reeking filth. Moral sanitation has its parallel with hygiene. But unless there be some such reason, the needless publication of such nastiness is more than unwise; it is positively harmful to the best interests of society. What wise parent wishes his sons and daughters to become familiar with the circumstantial particulars of murders, seductions, rapes, divorces, and other such filth from the slums; or with the necessarily disagreeable details of the morgue or the dissecting-room, unless there be some overweening reason why they should be so? Sometimes, as we have said, it is necessary to publish

such stuff. But it is the frequent and the needless publication that we protest against.

We have been led to these remarks by seeing lately in the *Press* and the *Times*, of this city, two articles in point. In the *Press*, nearly a column is given up to "Sights at the Morgue—The Horrible Curiosity that moves both Men and Women—Members of the Weaker Sex willing to Coin all manner of Deceptive Stories, and even to go without their Meals, to Look Upon a Corpse;" while the *Times* fills its column with an article on "Searching for a Corpse—A Bogus Burial and the Result—How the Medical College Vaults were Scoured for the Remains of Alfred Breslow by the Dead Man's Family—An Old Ghoul's Horrible Work in the Vats." Now, even if every word of these articles were true, what good was done? Was any abuse corrected? Any social ill-tendency lessened? Any man or woman—we need hardly add any child—made wiser, better, happier, or worthier in any way? Are not the tendencies and the results of such articles purely and simply bad and degrading, lowering the moral status and defiling more or less the mind of every reader?

But there is another point from which this may be viewed, and that is the personal one. In the article in the *Times*, the search is stated to have taken place in Dr. Keen's anatomical school, and any one reading it would suppose it to have occurred within a day or two. The fact is well known in the profession that this school has been closed since March, 1875, and we learn that the event referred to occurred *eight or nine years ago*, and that the whole article is a piece of descriptive fiction. It states that the corpse was "stolen," whereas, even if the body ever were delivered there (of which there is not the slightest proof), it was delivered by the Coroner, according to law, and only a wise courtesy on Dr. Keen's part allowed any search at all. That the bodies in the "black basin" or "corpse vat" were, in turn, "gaffed with an iron hook," any doctor knows is false, while the disgusting description of the "ghoulish fisherman waist-deep among the ghastly contents of the vat," even if it were true, would mark the reporter as the "ghoul."

We have said enough of its influence on the public; but must it not also injuriously and unjustly affect Dr. Keen's standing in the community? What layman that reads it but feels a shudder and imagines that Dr. Keen countenances stealing bodes, and is a frequent spectator of such disgusting sights, instead of this being, as we are informed, the solitary instance of any such search during his ten years of teaching at the school, and that then it was done with due decorum?

The effect on anatomical science, too, is not slight. The public are naturally very jealous of dissection. The days of Burke and of the "resurrectionists" are not so far away but that they still have their weight. Should the public press, recognizing the value and the absolute necessity of dissection, make it appear as horrible and revolting as possible, and lead legislatures and people to cripple and obstruct it wherever they can? The question answers itself.

Good morals, the advancement of medical science, and personal rights, all are injured by such publications.

THE RELATIVE VALUE OF LEGAL AND MEDICAL SERVICES.

IN view of the opposition even to the moderate compensation proposed to be awarded to the physicians of the late President Garfield (for it should be remembered that no bills have ever been presented), we desire to call attention to the fees paid by the Government to the lawyers in the "Lewis Will Case."

The amount bequeathed to the Government by Mr. Lewis towards the payment of the national debt was about $1,500,000. His natural heirs contested the will. Four extra lawyers were engaged as counsel for the United States, and they *compromised* the suit at $1,000,000, and then sent in bills amounting to $105,250! The Court cut them down to an aggregate of $72,750, and this sum has just been paid without raising a murmur in Congress, where there is evidently no difficulty in appreciating the value of *legal* services, even when the Government does not gain the suit. Mr. Gilchrist (who modestly had demanded $29,000), Mr. Keasbey, and Mr. Pierrepont each received $20,000, and Mr. Parker $12,750.

We commend to members of Congress a comparison of the time, labor, skill, and responsibility involved in compromising the Lewis Will Suit and in attending President Garfield through his long and fatal illness, with the sums actually paid by the Government for professional services in the former case and proposed to be paid in the latter.

DR. JOHN BROWN.

IN the July number of *Good Words* is a short sketch of Dr. John Brown, by Rev. Dr. Walter C. Smith, which we commend to our readers as one of the most graceful and appreciative notices that we have seen. Lively, witty, admirably written, Dr. Smith's article presents Dr. Brown to us in a most life-like manner. The portrait on wood is by far the best we have seen; no one who looks on that refined and noble face can for a moment doubt that it is the index of the pure and lovely soul within.

John Brown's place in literature is assured, self-distrustful as he unfortunately was to a degree; he

has left us but little, but that little is all pure gold. Had he written nothing else than "Rab," his fame would be permanent. But "Marjorie Flemming," "Our Dogs," his sketch of his father, and of Dr. Chalmers, well show the power and the pathos, the quaint humor and the thoughtfulness of the man, the like of which blended with a style so polished and a scholarship so broad, it is not often given to us to see. Holmes of the present day, Lamb of the past, are similar spirits, yet each unlike.

If any of our readers have missed the rare pleasure of his books, let them first read Dr. Smith's sketch, and then every page that John Brown has left.

REVIEWS.

EXCISION OF THE TONGUE: THE SUBSTANCE OF A PAPER READ BEFORE THE SURGICAL SECTION OF THE INTERNATIONAL MEDICAL CONGRESS, HELD IN LONDON, 1881. Reprinted from *The Lancet*, October 22 and 29, 1881. By WALTER WHITEHEAD, F.R.C.S.E., F.R.S. Edin., etc. 8vo. pp. 18. London: J. & A. Churchill, 1881.

THE author's object, in the interesting paper before us, seems to be two-fold: 1st, the advocacy of the method of removing the whole tongue, with scissors, through the mouth, for cancerous new formations; and 2d, the presentation of a plea for more accuracy in noting and reporting cases operated upon for these growths in whatever way it is done.

In both respects he has succeeded admirably. After referring to his first operation with scissors, in 1877, he describes the steps of this method, and gives a table of 28 such operations (15 by himself), with only one death as the immediate result of the operation. (Two other deaths occurred *after* the operation, but they resulted from remote causes.)

Mr. Whitehead, after considerable experience in removing the tongue by different methods, prefers the one under discussion, as being simple, easy, usually free from troublesome hemorrhage, and not liable to be followed by septic absorption. He entirely dissents from a statement of Prof. Stokes, that cutting operations for removal of the tongue are especially liable to the occurrence of hemorrhage and septic infection, saying that, from his own experience and the examination of records of over 250 cases, he should say "the danger from hemorrhage, when either the knife or scissors is used, is simply *nil*."

The use of the *écraseur* and of the galvano-cautery he opposes. Billroth's plan of ligating the lingual arteries before removing the tongue through the mouth, he thinks might be preferable to his own method, when more than the tongue was to be removed.

When the question of the actual results of operations for the removal of cancerous growths is raised, opinions are apt to differ very much. The author, speaking from cases where years of peace and immunity from apparent disease have followed *thorough* extirpation, advocates running no risk of leaving any portion of the disease behind, but to excise the whole tongue when the new tissue has attained any considerable extension.

The importance of this subject is apparent when it is considered that the deaths from cancer in England, which in 1851 numbered 5,218, numbered 12,799 in 1879, and the fact, as the author says, that "We have no reason to suppose at the present day that the internal administration of medicine, or that the topical application of drugs" (we suppose he does not include caustics), "has the smallest influence in arresting the progress of cancer; consequently, unless surgery can accomplish this, we must regard the disease as hopelessly incurable."

The pamphlet concludes with a plan for blanks, to be filled up in recording cases of excision of the tongue, which can be commended to all hospital surgeons.

CORRESPONDENCE.

THE UNIVERSITY OF LEYDEN, OLD AND NEW.

SEVEN years ago, February, 1875, the University of Leyden celebrated its three hundredth anniversary with a jubilee of ceremonies appropriate to such an occasion. An existence of three centuries would seem to be enough of itself to inspire a feeling of reverence, but Leyden has higher claim to fame than comes of mere survival through centuries of time. Few institutions of learning in the world can show such a distinguished roll of names among its teachers, and none has ever exerted a deeper or more lasting influence upon the minds of men. New sects of religion were founded or advocated here by Arminius and Gomar, whose followers kept up their acrimonious disputes for a century after their death, and at one time almost divided the religious world. Here lived and taught Sulmasius, and Scaliger, and Grotius, and Descartes, the same Cartesian who said that "if it be possible to perfect mankind, the means of doing it would be found in medical science," and here lived and taught, and hither flocked to hear him students from all parts of the civilized world, Herman Boerhaave, the greatest clinician of his day. A fine bronze monument to him stands just in front of the hospital grounds, looking out upon the little stream, part of the last of that classical river, the Rhine, as it winds its sluggish way to the sea, and facing a bit of landscape set off with a fine old Holland windmill, just such a picture or poem it makes as a painter might put upon canvas, or a poet into song. In the old church of St. Peter, in the town, is his tomb, on which there is an urn of black marble encircled with a wreath, and bearing upon its supporting shaft the simple inscription "*Salutifero Boerhavii genis sacrum.*" His portrait is given a prominent place among those of all the most famous professors of Leyden in the great room of the Senate, which we would call the faculty-room, of which all the guide books quote Niebuhr as saying in his Roman History that "no locality in Europe is so memorable in the history of science as this venerable hall." It is, in truth, an awe-inspiring room, not only to the green-room candidate, but to any one who has in his soul anything at all of the "spirit of discipleship." Its four walls are literally tapestried with the portraits of famous men, and a delightful relief it is, after a long contemplation of the stupid, heavy figure-heads of the nobility in the various museums, or the ecstatic zealots in the churches, to look upon these mild, benignant, faces in which the light of reason conspicuously shines.

Leyden has now only about eight hundred students (three hundred medical), but the great decline in number is due not to any declension in its attractions, but to the comparative decadence of the nation itself. At one time Holland was mistress of the seas, and was the most prominent power of Europe, after Spain, but she is now reduced, barring her Indian colonies, to a little strip of ground which she has to continually fight the sea to maintain, and which we might say, being mostly below its level, properly belongs to the sea. So the Dutch language is spoken over a very limited sur-

face of the earth. Nobody outside of Holland cares to learn it, and hence, as all instruction here is imparted either in Dutch or in Latin, which is being less used every day, the students of Leyden are pretty much all from Holland. Moreover, Holland has several other universities, at Gromingen, at Amsterdam, at Utrecht, each of which draws its proportion of students away from Leyden. So far as concerns the "inducements," or, as the college circulars say with us, "the facilities," of instruction, they are better in Leyden than ever before. There may be a larger, but there is not in Europe a finer, collection than is found in the Museum of Natural History, nor is there anywhere a finer, or better arranged, or better sustained museum of comparative anatomy. The clinical departments were never as large or as well conducted as now, and the cost of living, which our college circulars never fail to mention, is reduced to figures which might be anticipated in a city with houses enough for 100,000 inhabitants, its population once, reduced to 40,000, its population now. There is, hence, a corresponding "freedom from temptation," this for the benefit of the academic department (medical students being everywhere safe), as it would be hard to find a place so thoroughly invested with the "holy calm" of academic shades.

Of the museum of anatomy, I have already made mention, but something more than mention should be made of such a rich and varied cabinet. It is embraced in three large rooms whose centres are covered with tables, and whose walls are lined with cases containing the specimens, all under glass. The osteological specimens are perfectly white, the fine macroscopic (not microscopic) shavings showing the architecture of bone, being as thin as paper, and as white as snow. Of the wet specimens, I may say that I saw none that were not perfectly clear, and this fact bespeaks a care in original preparation which curators and prosectors will understand. The section illustrative of embryology and teratology is singularly fine, and the pathological collection of scoliotic skeletons is almost unique. Among the curiosities I was shown the epidermis of nearly the entire hand of an infant, a flake or two being lacking from the palmar surface; and, among the calculi, an enormous phosphatic stone nearly as large as the fist, with one end in cauliflower excrescence, like spiculæ of newly-fallen snow, and one large calculus about the size of a hen's egg, quite as long but not more than half as thick, removed by the patient himself with the knife, an old shoe-knife, and was informed that the patient lived after the operation, which was supra-pubic, of course, for twenty-three years.

Having noticed that the plants in the botanical garden were arranged after the system of Linnæus, who taught here once, by the way, though not in the University, I had the curiosity to ask the prosector of anatomy what theory of development was taught here now. "Why," he said, with a smile, "no anatomist, now-a-days, teaches any other theory than that of Darwin."

J. T. W.

LEYDEN, JULY 15, 1882.

"PROFESSIONAL POACHING."

To the Editor of THE MEDICAL NEWS.

SIR: The discussion of the New York Code of Ethics, in your valuable journal, has presented the new departure in its true relations to the profession and laity. And now, while the Saratoga season is upon us, and we are moving amid its varied pleasures and experiences, may I trespass upon your columns with some reflections upon matters professional, in the light of the new and revised edition of this ethical gospel of peace, as set forth in one of its phases in February last. The sentiment of the profession has been emphatically expressed in many quarters in regard to this "progressive liberality" of the New York State Medical Society. There was, however, another feature developed at that meeting, having wider scope in its "liberality," and being more radical a "reform" than the changes in the Code which were at last adopted. We refer to the resolution offered by Dr. Roosa, which received the sanction of the majority of members voting; the vote being significant as a manifestation of the opinion of some in regard to the existing Code, and possibly in regard to a necessity for the existence of any code whatever. The resolution embodied the following: "That the only ethical offences for which they (the profession) claim the province to exercise the right to discipline are those comprehended under the commission of acts unworthy of physicians and gentlemen." Also, "That we enjoin the County Societies and other organizations in affiliation with us, that they strictly enforce the requirements of this Code."

The reported vote upon this was 39 in favor and 37 against, and, as it was considered by the President an amendment to the by-laws requiring a two-thirds vote, it was declared lost. In the light of such sentiment, we rise, Mr. Editor, to make inquiry. A few years ago questions of ethics were discussed in a prominent medical journal relative to the position of *metropolitan* and *rural* practitioners (as they were editorially termed) at places of summer resort. Now, it may be comfortable to leave the *metropolis*, and, straying out into the nooks and corners of the country, to pick up crumbs of professional experience that will meet the expense of summer travel and the demands of the landlord. The wearied metropolitan may find rest and refreshment in the process, and may add to his physical condition a muscular tone which will help him cheek it through if disturbed by reflections upon the mode and manner of his professional poaching. He may gain the ear of the hotel proprietor, and insinuatingly suggest the advantage it may be to the house to have him around, and he may seek acquaintance with each newly arrived guest, incidentally making mention of his metropolitan origin, and making the position more sure by the presentation of his professional card. The palm of the Ethiopian hall-boy may be impressed by a percentage on every professional call he may bring to the waiting practitioner, or the local paper may announce the arrival at the fashionable hotel of —— M.D., where he is to pass the season. The calculating practitioner may visit his professional brethren in the various cities and prepare the way for business by announcing the fact that he will be located thus and thus during the summer months, and patients may be referred to him while he rusticates amid the pleasures of his country surroundings. The patient may travel in search of improvement, bearing in his pocket the letter from his family physician that refers him to —— M.D., who will be found sojourning at some first-class hotel for *the season*, and when the crowd have departed, the harvest has passed, and the pickings grown poor, the sojourning M.D., will return to his house and home, waiting the coming of another season, when he again may seek rest, refreshment, and additional practice. We paint no imaginary picture, and in the light of experience, Mr. Editor, rise to the inquiry, where in all this is the code of the gentleman? Are these practitioners within the code as pictured by the genial Roosa? Had this liberal code been adopted (and from the vote there seemed not a few who favored it), how were such gentlemen to be reached?

The second clause of the resolution enjoins upon County Societies, that they strictly enforce gentlemanly requirements, and we inquire how and in what way could a county society enforce upon these wandering practitioners gentlemanly requirements which they so

instinctively and so industriously ignore? As these gentlemen are practising in Saratoga County, is it within the province of the Saratoga County Medical Society to exercise the right of gentlemanly discipline? or would these nomadic professionals be amenable to some other Society, which shall teach them professional courtesy? They are legally qualified as practitioners, if not ethically qualified in the manifestation of exemplary traits of gentlemanly character, and one could hardly expect, on their part, any especial regard for ethical considerations, whether embraced under the existing Code or that proposed by Dr. Roosa. County Societies might find it a weighty task sustaining the privileged position of interpretation of gentlemanly acts and enforcement of gentlemanly discipline. Timothy Titcomb, in one of his essays, remarks: "It seems to me, either there is a great deal of human nature in a pig, or that there is a great deal of pig in human nature;" and we are glad the resolution did not prevail in this view of our professional relations during the harvest of a Saratoga season.

INQUIRER.

SARATOGA SPRINGS, Aug. 17, 1882.

NEWS ITEMS.

LONDON.

(From our Special Correspondent.)

THE ROYAL COLLEGE OF PHYSICIANS ON MEDICAL ADVERTISING.—The Fellows of the Royal College of Physicians of London met in solemn conclave last week to consider a resolution condemning advertisements of medical books in the lay press, and the giving of medical testimonials to the proprietors of mineral waters, medicinal preparations, etc. An animated discussion ensued, and ultimately the following resolution was passed: "That the system of extensively advertising medical works, and the custom of giving laudatory certificates of medicinal and other preparations and medical and surgical appliances, whether for publication or not, is misleading to the public, derogatory to the dignity of the profession, and contrary to the traditions and resolutions of the Royal College of Physicians."

It was pointed out that extensive advertising in the medical press was deceptive, as tending to associate special names with particular diseases. An interesting feature of the debate was the confession by a distinguished physician that he received five guineas for a certificate praising a "favorite natural aperient." We now know the value of the much-advertised recommendations of this water.

AN EASY METHOD OF DETECTING THE BACILLUS TUBERCULOSIS FOR DIAGNOSTIC PURPOSES.—The corroboration of Dr. Koch's discovery of a *Bacillus tuberculosis* has been attempted by several histologists in London; and at the Laboratory of the Brown Institute in particular considerable labor has been expended in this direction, which has not met with success. Dr. Heron has obtained the bacillus by Ehrlich's process, but with this exception the specimens that have been used to demonstrate this newest "germ" have been imported from Germany. Now, however, one of our best microscopists, Dr. HENEAGE GIBBES, who has been remarkably successful in multiple staining, has hit upon a simple, and, he says, certain, method of detecting this bacillus, and one which brings it out so clearly that it can be demonstrated by a common microscope with only one-quarter inch objective, and no special means of illumination. The colors used are magenta crystals and chrysoidin; the latter is a brown, which does not stain the ground substance so intensely as vesuvin. They can be procured from the Badesche Anilin Fabrik, 22 Bush-lane, Cannon Street, E. C. The following are the formulæ he has used: Two grammes of magenta crystals, three grammes of pure anilin, twenty cubic centimetres of alcohol, specific gravity .830, twenty cubic centimetres of distilled water. Dissolve the anilin in the spirit, and then rub up the color with it in a glass mortar, adding the spirit gradually until it is all dissolved, then add the water slowly, while stirring, and keep in a stoppered bottle. Make a saturated solution of chrysoidin in distilled water and add a crystal of thymol to make it keep; a dilute solution of commercial nitric acid is made, one part of acid to two of distilled water. For sputum, the following process is the most simple: Spread a thin layer on a cover glass and let it dry; when quite dry pass it two or three times through the flame of a small Bunsen burner, and let it cool. Filter two or three drops of magenta solution in a watch glass, place the cover glass with the sputum downwards on the stain, taking care there are no air bubbles under it. Let it remain for fifteen or twenty minutes, then wash in the dilute acid until all color has disappeared; remove the acid with distilled water, when a faint color will return; then place the cover glass in the same manner as before on a few drops of chrysoidin filtered into the bottom of a watch glass, and let it remain a few minutes until it has taken on the brown stain; wash off the superfluous color in distilled water, and place the cover glass in absolute alcohol for a few minutes; remove and dry perfectly in the air; place a drop of Canada balsam solution on the cover glass and mount. Sections of hardened tissue are treated in the same manner with the necessary modifications.

EDINBURGH.

(From our Special Correspondent.)

EDINBURGH UNIVERSITY.—Mr. John Chiene, M.D., F.R.C.S. Ed., has been appointed by the curators to succeed the late Professor Spence in the chair of surgery. Mr. Chiene is a graduate of this university, and for four years immediately after obtaining his degree assisted Goodsir, and latterly Turner, in the anatomical department. He is thus an excellent anatomist, and this is further assured by the fact of his having held for several years the position of Examiner in Anatomy for the University degree. On leaving the Anatomical Department he commenced the practice of surgery in the city, working for the most part under the auspices of Professor Lister, who strongly advocated Mr. Chiene's claims for the chair. He was also intimately associated with Lister in his hospital work, and since that distinguished surgeon went to London, Chiene has been regarded as the principal exponent in Edinburgh of antiseptic surgery. Perhaps upon this ground more than any other, was Chiene selected to succeed Spence; and it is fitting that Edinburgh, as the birthplace of antiseptic surgery, should thus prominently acknowledge its merits. Mr. Chiene, although a young surgeon, has found time to greatly enrich the literature of both surgery and anatomy. He is the author of an excellent work on "Surgical Anatomy," and recently contributed to the "American Practitioner" a series of lectures on the "Elements of Surgery," which show how well he has grasped the principles of the Listerian treatment. His papers on "Healing by Blood-clot," and on "Bacteria in Healthy Organs" illustrate the originality of his mind and his extensive acquaintance with other branches of medicine, as well as those of surgery and anatomy. Mr. Chiene has also proved himself a most successful and enthusiastic teacher in the extra-mural medical school.

VIENNA.

(From our Special Correspondent.)

PROF. HERMANN NOTHNAGEL.—The following notice appeared recently in one of the Vienna newspapers:

"His Royal and Imperial Apostolic Majesty has been most graciously pleased, through his most high resolution of July 11, to call Dr. Hermann Nothnagel, Professor in the University of Jena, to be Regular Professor of Special Pathology and Therapy and of the Medical Clinic in the University of Vienna.

"CONRAD EYBESFELD,
"Minister of Education."

The selection of Prof. Nothnagel as Duchek's successor is very cordially received by professors, teachers, students, and the medical press in Vienna. The fact that Baron Conrad Eybesfeld, Minister of Education, did not allow himself to be influenced by the politicians, who were working for the interests of local candidates, is generally recognized. Prof. Bamberger, for some time past, has been in feeble health, and this circumstance has probably led to the sudden and entirely unexpected appointment of Prof. Nothnagel.

While, upon the one hand, Prof. Nothnagel, as Professor of the First Medical Clinic in the "Allgemeine Krankenhaus," will occupy the same position which ten years ago Oppolzer and Skoda held, and must thereby recognize in the appointment reward for his great work; on the other hand, the Faculty of Medicine of the University of Vienna must congratulate itself upon the acquisition of a man who will restore to the school the prestige in clinical medicine which has gradually been lost through the development of the so-called "specialties."

Prof. Nothnagel was born September 28, 1841, in Alt-Sutzeporche, a small village near Berlin. He was the son of a physician. His gymnasial studies were completed in Königsberg in the Neumark; his medical studies, occupying the years 1859–1864, were pursued at the University of Berlin. He passed a brilliant examination before the State Board in the winter of 1864–'65, after he had obtained his degree of Doctor of Medicine on August 6, 1863.

The instructors who are especially to be named as influencing the formation of Nothnagel's medical character are Virchow and Traube. Traube was especially interested in his student, and remained in intimate friendship with him until his death.

In 1865 Dr. Nothnagel went to Königsberg, in Prussia, as the assistant of Leyden, when, in 1867, he became Privat-Docent, and taught auscultation, percussion, laryngoscopy, and electro-therapy. Leyden's influence led him to the study of nervous diseases, and this period may be regarded as the starting-point of his scientific life. In 1868–1870 he was a Privat-Docent in Berlin. In 1870 he transferred himself to Breslau in a similar capacity. In the same year his remarkable "Handbook of Therapeutics" appeared in Berlin; in 1874 the second, and in 1880 the fourth edition of this admirable work appeared. In Leipzig, in 1872, an essay upon the "Epileptic Seizure" attracted deserved attention. After two years' work in the University of Breslau, Dr. Nothnagel accepted a call, in the fall of 1872, as regular Professor of Therapeutics and Pharmacology in Freiburg, when he had charge of the Poliklinik, while Kussmaul was Professor of the Clinic.

In the summer of 1874 two professorships were offered to him at the same time—one in Zürich, made vacant by Biermer's departure: and one in Jena. He accepted the less brilliant position in Jena, in which city he has most zealously worked since his appointment. In 1875 and 1876 appeared his "Magnum Opus," "Handbook of Diseases of the Nervous System," consisting of two volumes, of which the one was edited by himself, in connection with Eulenberg, Ziemssen, Jolly, and J. Bauer; the other with the assistance of Obernier, O. Heubner, G. Huguenin, and E. Hitzig. Both volumes will be found in Ziemssen's "Handbook of Special Pathology and Therapy." Minor essays are contained in R. Volkmann's collection of clinical papers. Among them may be mentioned "Neuritis, in a Diagnostic and Pathological Point of View" (Leipzig, 1876); "Symptomatology of Intestinal Ulceration" (Leipzig, 1881). "The Influence of Opium upon the Intestinal Tract" has recently appeared in Virchow's Archives. One of his chief works is undoubtedly "The Topical Diagnosis of Diseases of the Brain" (Berlin, 1879).

PROF. V. LANGENBECK.—Langenbeck has resigned from the Berlin Medical Society, of which he has been a member since its foundation. Becoming ceremonies will be celebrated in honor of the retiring surgeon in Wiesbaden.

PROF. VOLKMANN.—Prof. Richard Volkmann has declined Langenbeck's Chair of Surgery in Berlin, and remains in Halle. The citizens of Halle are perfectly jubilant over the declination, as it certainly indicates a high regard for the honor and fame of the university of that city.

SUCCESSOR TO LANGENBECK.—Prof. Bergmann, in Würzburg, Prof. König, and Prof. Czerny were proposed as candidates for the vacant Chair of Surgery in the University of Berlin. Prof. v. Bergmann was elected.

LIGATURE OF THE INNOMINATE ARTERY.—MR. THOMSON'S patient died on Thursday, July 20, the forty-second day after ligature of the innominate artery. There was no recurrence of bleeding after the thirty-ninth day. The sinus was found to terminate in an ulcer, which involved the anterior wall of the junction of the innominate, carotid, and subclavian arteries. The innominate and carotid were filled with clot; the subclavian contained a clot occluding it to the extent of half an inch. The position of the ulcer was on the distal side of the ligature, the constricted portion of the innominate not being involved. The hemorrhage had apparently taken place from the innominate, as there was a recent blood-stain on the cardiac side of the clot. None of the vessels were pervious to water forced in with a syringe. The aorta was atheromatous. Consolidation was proceeding satisfactorily in the tumor. Excluding the successful case of Dr. Smith, of New Orleans, this is the second longest survival on record, Graefe's case having reached the sixty-seventh day, and Cooper's the thirty-fourth.—*British Medical Journal*, July 29, 1882.

GASTROSTOMY.—MR. LANGTON has recently performed this operation at St. Bartholomew's Hospital on a young child. The patient was suffering from a stricture of the œsophagus, produced by having swallowed a quantity of potash lye about six months earlier. The patient was seen at the consultation on June 22d, and Mr. Langton was then supported by his colleagues in the determination to attempt to relieve the child, who was nourished solely by enemata, by opening the stomach. Under these circumstances, the first part of the operation was performed on June 24th; and five days later the stomach was opened, and a soft tracheotomy tube introduced. The patient recovered well from the operation, and there was no general peritonitis; but it gradually sank, and died of exhaustion a week after the gastric fistula was first used for the introduction of food.—*Brit. Med. Journ.*, July 15, 1882.

A NEW AND CHEAP DISINFECTANT.—Dissolve half a drachm of nitrate of lead in a pint of boiling water; also two drachms of common salt in a bucket of water;

pour the two solutions together; allow the sediment to precipitate, and the clear supernatant fluid will be a chloride of lead. This will deodorize and disinfect sinks, water-closets, or drains, and a cloth dipped into it will sweeten a fetid atmosphere.—*Dublin Medical Journal*, May, 1882, from *Australasian Medical Gazette*.

THREATENED OR ACTUAL EPIDEMICS.—The Supervising Surgeon-General of the U. S. Marine-Hospital Service, under date of August 9, 1882, has issued a circular to Medical Officers of the Marine-Hospital Service, and officers of State and Municipal Boards of Health, informing them that Congress, at its last session, enacted that

"The President of the United States is hereby authorized, in case of a threatened or actual epidemic, to use a sum not exceeding one hundred thousand dollars, out of any money in the Treasury not otherwise appropriated, in aid of State and local boards, or otherwise in his discretion, in preventing and suppressing the spread of the same."

He further informs them that the President has decided to employ this contingent appropriation through the agency of the Treasury Department, and that, in case of a threatened or actual epidemic, immediate action will be taken, upon application from the Governor of a State addressed to the Secretary of the Treasury.

The attention of Medical Officers of the Marine-Hospital Service is called to the following paragraphs of the regulations governing this service, approved by the Secretary of the Treasury November 10, 1879:

Paragraph 61.—"Medical Officers and Acting Assistant Surgeons of the Marine-Hospital Service will inform themselves fully as to the local health laws, and the regulations based thereon and in force at their respective ports and stations, and will comply strictly therewith."

Paragraph 62.—"Medical Officers and Acting Assistant Surgeons are, under the direction of the Supervising Surgeon-General, required to observe and to aid in executing the quarantines and other restraints established by the health laws of any State, and to report forthwith to the said Surgeon-General any important event or fact that may come to their knowledge bearing upon the importation, outbreak, or spread of cholera, yellow fever, small-pox, typhus, or other epidemic disease, at or near their respective stations."

IMMIGRANT INSPECTION SERVICE.—DR. JOHN H. RAUCH, supervising inspector in the Illinois district, submits the following report for the month of July, of the operations of the Immigrant Inspection Service, N. B. H., in the district under his supervision.

During the month an aggregate of 21,000 immigrants were inspected by the assistant inspectors, who found about sixteen per cent. of these unprotected, liable to contract small-pox and to propagate the disease. The necessary precautions were taken with all of these cases, as well as with one case of varioloid found in transit, and several convalescents, one being an immigrant removed from a train and treated in the small-pox hospital at Rochester during the month of June.

Although there is a marked improvement in the character of the protective work done on shipboard, as compared with that noted on beginning inspections, this is by no means uniform, as is seen by the following extracts from the assistant inspectors' notes of careless, imperfect or neglected vaccinations and revaccinations:

Steamship *Republic*.—"Practically worthless; no adult vaccination."

Strasburg.—"Very poor; only eleven successful out of 340 vaccinations—result evidently due to want of care on part of steamship surgeon."

General Herder.—"None showed successful vaccination."

Hermann.—"Only thirteen properly protected out of 410; the vaccination performed on shipboard very unsatisfactory. All passengers provided with *protection cards*."

The *Strasburg* and *Hermann* are regular Baltimore packets, and the latter, at least, is known to have been the means of introducing small-pox into five localities in Illinois during the past spring.

It might be profitable to inquire to what extent such vessels and the neglect of their surgeons are responsible for the present prevalence of small-pox in Baltimore.

On July 28, among the passengers by the steamer *Erin*, were found ten convalescents who had had small-pox within a month before leaving Ireland.

Notwithstanding that the aggregate number of inspections was less in July than in the preceding month, the relative number is much larger. Immigration has probably fallen off one-half since May last, and it is believed that of the total number now arriving, very few find their way into Illinois or cross the State without being subjected to one or more rigorous inspections. The reports of small-pox outbreaks in the region west of the Mississippi River have been notably less during July, while in this State there has not been a single case reported during the month, outside of Chicago. The following table shows the steady decline of the disease in that city:

Month.	Cases Reported.	Deaths.
April,	321	92
May,	281	65
June,[1]	124	29
July,	44	11

At the close of the month there were only ten cases under treatment in the city, and one in the State at large.

In other districts of the service it is observed that increased familiarity with the work has secured increased efficiency, and thus materially lightened a labor which was found to be very onerous during the first month. For example: the vaccinations found to be necessary among passengers arriving over the Grand Trunk road in June were very nearly 36 per cent. of the total inspections. During July, owing to the increased number of vaccinations at Port Huron, Mich., this percentage has been reduced to 8.3 per cent.

Many cases of cholera infantum, measles, and whooping-cough are met with by the inspectors, who, so far as time and opportunity serve, render such medical assistance as is necessary.

The railway service has continued to afford every desired facility to the inspectors, and, aside from the advent of an occasional unannounced train over a connecting line, every emergency has been promptly met. The coaches for immigrant passengers are kept in good sanitary condition, and the general welfare of these people seems to be consulted on business principles.

From June 1st to July 31st there were 47,948 inspections, and 7799 vaccinations.

HEALTH IN MICHIGAN.—Reports to the State Board of Health, for the week ending August 5, 1882, indicate that cholera morbus, cholera infantum, and diarrhœa, have considerably increased, that puerperal fever has increased, and that tonsillitis and whooping-cough have decreased in area of prevalence.

It appears that the increased prevalence of cholera

[1] Inspections began June 1.

morbus, cholera infantum, and diarrhœa was coincident with a high temperature, a great increase in relative and in absolute humidity; also with a low atmospheric pressure, and a considerable reduction in the day ozone.

Including reports by regular observers and by others, diphtheria was reported present during the week ending August 5th, and since, at 20 places, scarlet fever at 8 places, measles at 11 places, and small-pox at 17 places, as follows: in Deerfield township, Lapeer Co., July 30; at Lansing (one case, convalescent), July 31; in Crystal township, Montcalm Co. (4 cases), August 1; in Rapid River township, Kalkaska Co. (4 cases), in Orange, in Sebawa, in Danby, Ionia Co., and in Mancelona township, Antrim Co. (3 cases), August 3; at Mt. Morris, Genesee Co. (one case, convalescent), August 4; at Detroit (3 cases), Flint, and Portland (one case), August 5; in Walker township, August 7; at Grand Rapids, August 9; at Clio, Genesee Co., in Ionia township, and near Carson City, Montcalm Co., August 10.

PROF. V. LANGENBECK, on July 24th, on the occasion of his retirement from the Professorship of Surgery, had the compliment of a brilliant reception and collation tendered him by the students of Berlin.

THE BRITISH MEDICAL ASSOCIATION held its Fiftieth Annual Meeting at Worcester, August 8, 9, 10, and 11. The programme shows good scientific work in the eight sections. The Address in Medicine will be delivered by Dr. Wade, of Birmingham, the Address in Surgery by Dr. William Stokes, of Dublin.

Dr. Austin Flint, of New York, will read a paper in the Medical Section on the Self-limited Duration of Pulmonary Disease.

We hope to promptly lay before our readers a full account of the meeting, from our Special Correspondent.

PRIZE OF THE ACADÉMIE DE MÉDECINE AWARDED TO DR. H. J. BIGELOW.—The prize of 10,000 francs founded by the Marquis d'Argenteuil, granted every six years to the author publishing the most important advance in urinary surgery, has been divided between Dr. Henry J. Bigelow, for his work on The Treatment of Strictures of the Urethra by *dilatation urodyname*, and Dr. Th. Anger, for his essays on New Thermo-Cautery, Lithotomy Instruments, and Peno-scrotal Hypospadias. Dr. Bigelow receives 6000 francs and Dr. Anger 4000 francs.

OBITUARY.—The *British Medical Journal* announces the death of PROF. F. M. BALFOUR, in Switzerland, from a fall in the Alps.

Francis Maitland Balfour, the recently elected Professor of Animal Morphology in Cambridge, was born in 1851, received his early education at Harrow, and received his degree at Cambridge, where, even as an undergraduate, he distinguished himself by important embryological work. After graduation he went to the Zoölogical Station, at Naples, and there collected the material for his valuable memoir on the Elasmobranchs. He was elected Fellow of the Royal Society, in 1878, and in November obtained the high distinction of a Royal Medal, and in 1880, he received the degree of LL.D. from the University of Edinburgh. He was the author of a multitude of miscellaneous papers on embryology and comparative anatomy, and of the best text-book extant on comparative embryology.

—— On the 13th of July, JOSÉ LAURENÇO DA LUZ, the Portugese surgeon, said by the *O Correio Medico de Lisboa* to have been the peer of Dupuytren and Astley Cooper. Da Luz was Professor of Surgery and Director in the Medico-Chirurgical College of Lisbon, and the founder of the first medical journal published in that city, the *Jornal da Sociedade das Sciéntias Medicas*, to which he contributed a number of valuable articles.

OFFICIAL LIST OF CHANGES OF STATIONS AND DUTIES OF OFFICERS OF THE MEDICAL DEPARTMENT, U. S. ARMY, FROM AUGUST 8 TO AUGUST 14, 1882.

PROMOTIONS.

Colonel CHARLES H. CRANE, Assistant Surgeon-General, promoted Surgeon-General, with the rank of Brigadier-General, to date from July 3, 1882, *vice* Barnes, retired.

Lieutenant-Colonel CHARLES C. KEENEY, Surgeon, to be Surgeon, with the rank of Colonel, June 30, 1882, *vice* Cuyler, retired.

Lieutenant-Colonel JOHN F. HEAD, Surgeon, to be Surgeon, with the rank of Colonel, June 30, 1882, *vice* King, retired.

Major JOSEPH B. BROWN, Surgeon, to be Surgeon, with the rank of Lieutenant-Colonel, June 30, 1882, *vice* Simons, retired.

Major DAVID L. MAGRUDER, Surgeon, to be Surgeon, with the rank of Lieutenant-Colonel, June 30, 1882, *vice* Keeney, promoted.

Major CHARLES PAGE, Surgeon, to be Surgeon, with the rank of Lieutenant-Colonel, June 30, 1882, *vice* Head, promoted.

Captain JOHN BROOKE, Assistant Surgeon, to be Surgeon, with the rank of Major, March 2, 1882, *vice* Frantz, deceased.

Captain WM. H. GARDNER, Assistant Surgeon, to be Surgeon, with the rank of Major, June 23, 1882, *vice* Notson, deceased.

Captain CHARLES SMART, Assistant Surgeon, to be Surgeon, with the rank of Major, June 30, 1882, *vice* Brown, promoted.

Captain WM. S. TREMAINE, Assistant Surgeon, to be Surgeon, with the rank of Major, June 30, 1882, *vice* Magruder, promoted.

Captain MORSE K. TAYLOR, Assistant Surgeon, to be Surgeon, with the rank of Major, June 30, 1882, *vice* Page, promoted.

HARTSUFF, ALBERT, *Major and Surgeon.*—Having reported at these headquarters on 3d inst., surrendering unexpired portion of his leave of absence, will proceed to Fort Union, New Mexico, and report to the commanding officer for duty.—*S. O. 153, Department of the Missouri, August 4, 1882.*

BROWN, J. M., *Major and Surgeon.*—Assigned as Attending Surgeon at headquarters Department of the South, in addition to his duties as Post Surgeon at Newport Barracks, Kentucky.—*S. O. 79, Department of the South, August 10, 1882.*

WILCOX, F. E., *Captain and Assistant Surgeon.*—To accompany Troop F, First Cavalry, to Fort Walla Walla, and then repair to these headquarters for assignment to duty at Vancouver Barracks.—*S. O. 106, Department of the Columbia, July 31, 1882.*

TAYLOR, M. E., *Captain and Assistant Surgeon.*—Relieved from duty at Jefferson Barracks, Missouri, and to report by letter to the Surgeon-General.—*S. O. 185, A. G. O., August 10, 1882.*

POWELL, J. L., *First Lieutenant and Assistant Surgeon.*—Confirms telegraphic instructions of this date to allow the Lieutenant-Colonel Tenth Cavalry, and Troops G and L of that Regiment, and Assistant Surgeon Powell to continue temporarily, and until further orders, at Fort Stockton, Texas.—*S. O. 84, Department of Texas, August 9, 1882.*

MCCREERY, G., *First Lieutenant and Assistant Surgeon.*—Transferred from Fort Apache to Whipple Barracks, Arizona Territory.—*S. O. 119, c. s., Department of Arizona.*

ELERT, R., *First Lieutenant and Assistant Surgeon.*—Relieved from duty at Fort Walla Walla, Wyoming Territory, to accompany Troop E, First Cavalry, to Boise Barracks, and, on arrival there, relieve Assistant Surgeon Wilcox from duty at that post.—*S. O. 106, c. s., Department of Columbia.*

RAYMOND, H. I., *First Lieutenant and Assistant Surgeon.*—Transferred from Whipple Barracks to Fort Apache, Arizona Territory.—*S. O. 119, Department of Arizona, August 3, 1882.*

EGAN, P. R., *First Lieutenant and Assistant Surgeon.*—Relieved from duty at David's Island, New York, and to report in person to the Commanding General Department of Arizona for assignment to duty.—*S. O. 185, c. s., A. G. O.*

WIKEMAN, WM. J., *First Lieutenant and Assistant Surgeon.*—Relieved from duty at Columbus Barracks, Ohio, and to report in person to the Commanding General Department of the Platte for assignment to duty.—*S. O. 185, c. s., A. G. O.*

THE MEDICAL NEWS *will be pleased to receive early intelligence of local events of general medical interest, or of matters which it is desirable to bring to the notice of the profession.*

Local papers containing reports or news items should be marked.

Letters, whether written for publication or private information, must be authenticated by the names and addresses of their writers—of course not necessarily for publication.

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